

# **TASK FORCE ON EMPLOYEE WELLNESS AND CONSOLIDATION OF AGENCY GROUP INSURANCE PROGRAMS**

Established by Montgomery County Council Resolution 17-107



Sue DeGraba	Montgomery County Public Schools
Karen DeLong	American Federation of State, County & Municipal Employees Local 2380
Joan Fidler	Public Member
Erick Genser	International Association of Firefighters Local 1664
Denise Gill	Fraternal Order of Police Lodge 35
Wes Girling	Montgomery County Government
Lee Goldberg	Public Member
Paul Heylman	Public Member and Chair, Consolidation Committee
Tom Israel	Montgomery County Education Association
Rick Johnstone	Montgomery County Public Schools
Jan Lahr-Prock	Maryland-National Capital Park and Planning Commission
Mark Lutes	Public Member
Thomas McNutt	Public Member
Brian McTigue	Public Member
Edye Miller	Montgomery County Association of Administrators and Principals
William Mooney	Public Member and Task Force Chair
Richard Penn	American Association of University Professors
Gino Renne	Municipal & County Government Employees Organization Local 1994
Farzeneh Riar	Public Member and Chair, Wellness Committee
David Rodich	Service Employees International Union Local 500
Carole Silberhorn	Washington Suburban Sanitary Commission
Arthur Spengler	Public Member
Dr. Ulder Tillman	Montgomery County Government
Lynda von Bargaen	Montgomery College
Michael Young	Fraternal Order of Police Lodge 30

**FINAL REPORT**  
**December 2, 2011**

December 2, 2011

Dear Council President Ervin,

On behalf of the 25 members of the Task Force on Employee Wellness and Consolidation of Agency Group Insurance Programs, I am pleased to submit our final report to the County Council. We look forward to presenting the report to the Council on Tuesday, December 6, 2011.

As you know, the Task Force's membership included designees from the County and bi-County agencies, the bargaining units for these agencies, and public members. The Council asked our group to address two major issues related to the provision of health care benefits to employees and retirees across the agencies: (1) Employee wellness and disease prevention programs, and (2) Consolidation of plan design and administration.

The Task Force held its initial meeting in late July and met weekly from early September through mid-November, with a final meeting on November 29. During this time, the Task Force received written information and multiple presentations on a wide range of issues related to the costs and structure of health benefits, wellness, disease management, and the management of health care costs through improved plan design.

I want to thank all of the Task Force members for their outstanding attendance and energetic participation in all aspects of the Task Force's work. The agency representatives provided overviews of current program and process, the union representatives emphasized their strong ongoing interest in the health and well being of employees and containing costs through improved health and health care, and our public members brought new perspectives and knowledge about ongoing changes in the field of health care benefits to the table. The collaborative spirit demonstrated by Task Force members throughout the study period facilitated a healthy and robust discussion of the complex issues that our group was asked to examine.

In particular, I want to acknowledge Farzanah Riar, who served as Chair of the Task Force's Wellness Committee, and Paul Heylman, who served as Chair of the Task Force's Consolidation Committee. They both gave generously of their time and professional expertise, especially when it came to developing the information, analysis, and recommendations that are contained in the final report.

Council President Valerie Ervin  
December 2, 2011

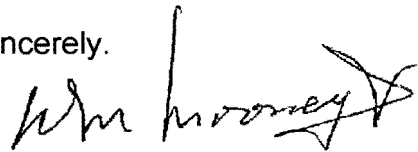
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The report contains a summary of the background information reviewed by the Task Force, and specific recommendations and comments from the Wellness Committee and Consolidation Committee. In sum, the Task Force recommends:

- The collection and analysis of aggregate health care claims data for all employees, retirees, and dependents covered by the County and bi-County agencies' health insurance plans. The County currently has over 100,000 enrolled members in agency plans. The Task Force encourages the County to use this buying power.
- The development and promotion of a workplace culture that values employee wellness and encourages the partnering of employees, employers, and health care providers to improve health outcomes.
- The implementation of wellness and disease management programs based on best-practices, to include outcome measures related to better management of chronic conditions that should contain costs through prevention of high-cost hospitalizations and medical services.
- Recognition that there are no simple solutions to bending the health care cost curve downward. And further, improvements will take time, may require upfront investment, and will likely be incremental.

It has been an honor and pleasure for us to serve on this Task Force. We hope the information and recommendations contained in our report provides a framework for continued Council action related to enhancing the wellness of employees, retirees, and their dependents, as well as the value of health care benefits offered by the County and bi-County agencies.

Sincerely,

A handwritten signature in black ink, appearing to read "William Mooney", with a stylized flourish at the end.

William Mooney, Chair

# **Task Force on Employee Wellness and Consolidation of Agency Group Insurance Programs**

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# TASK FORCE ON EMPLOYEE WELLNESS AND CONSOLIDATION OF AGENCY GROUP INSURANCE PROGRAMS

EXECUTIVE SUMMARY  
DECEMBER 2, 2011

On July 19, 2011, the County Council appointed the Task Force on Employee Wellness and Consolidation of Agency Group Insurance Programs. The membership included designees from the County and bi-County agencies, the bargaining units for these agencies, and public members. The Council asked the group to address two major issues related to the provision of health care benefits to employees and retirees across the agencies: (1) employee wellness and disease prevention programs, and (2) consolidation of plan design and administration. The Task Force was not asked to examine the issue of "cost share", i.e., how the health premium cost is split between each agency and its respective employees.

## Task Force Members

<b>Sue DeGraba</b> , Montgomery County Public Schools	<b>Brian McTigue</b> , Public Member
<b>Karen DeLong</b> , American Federation of State, County, and Municipal Employees Local 2380	<b>Edye Miller</b> , Montgomery County Association of Administrators and Principals
<b>Joan Fidler</b> , Public Member	<b>William Mooney</b> , Public Member & Task Force Chair
<b>Erick Genser</b> , International Association of Fire Fighters Local 1664	<b>Richard Penn</b> , American Association of University Professors
<b>Denise Gill</b> , Fraternal Order of Police Lodge 35	<b>Gino Renne</b> , Municipal & County Government Employees Organization Local 1994
<b>Wes Girling</b> , Montgomery County Government	<b>Farzenh Riar</b> , Public Member & Chair, Wellness Committee
<b>Lee Goldberg</b> , Public Member	<b>David Rodich</b> , Service Employees International Union Local 500
<b>Paul Heylman</b> , Public Member & Chair, Consolidation Committee	<b>Carole Silberhorn</b> , Washington Suburban Sanitary Commission
<b>Tom Israel</b> , Montgomery County Education Association	<b>Arthur Spengler</b> , Public Member
<b>Rick Johnstone</b> , Montgomery County Public Schools	<b>Dr. Ulder Tillman</b> , Montgomery County Government
<b>Jan Lahr-Prock</b> , Maryland-Nat'l Capital Park & Planning Comm.	<b>Lynda von Barga</b> , Montgomery College
<b>Mark Lutes</b> , Public Member	<b>Michael Young</b> , Fraternal Order of Police Lodge 30
<b>Thomas McNutt</b> , Public Member	

The Task Force held its initial meeting in July and met weekly from early September through mid-November, with a final meeting on November 29. In sum, the Task Force recommends:

- The collection and analysis of aggregate health care claims data for all employees, retirees, and dependents covered by the County and bi-County agencies' health insurance plans. This population currently totals over 100,000 enrolled members.
- The development and promotion of a workplace culture that values employee wellness and encourages the partnering of employees, employers, and health care providers to improve health outcomes.
- The implementation of wellness and disease management programs based on best-practices, to include outcome measures related to better management of chronic conditions.
- Recognition that there are no simple solutions to bending the health care cost curve downward. And further, that improvements will take time, may require upfront investment, and will likely be incremental.

## **RECOMMENDATIONS AND COMMENTS FROM THE WELLNESS COMMITTEE**

The Wellness Committee reviewed the potential benefits of implementing wellness and disease management programs. The experience of other jurisdictions shows that, over time, these programs can improve employee health and prevent illness, which in turn can reduce absenteeism and increase productivity. In short, these initiatives have demonstrated a positive return on investment through increasing the health and well-being of employees, retirees, and their dependents and reducing the cost of health care claims.

### **Health Care Claims and the Impact of Chronic Disease**

For the County and bi-County agencies, claims payments comprise about 95% of total health benefits costs. As a result, any substantial impact on future health care costs requires a reduction in the cost of claims. The Committee's review of literature on the impact of chronic disease on overall costs found that:

- As a general rule, approximately 80% of an organization's health care dollars are spent on 20% of the individuals covered.
- The Roberts Wood Johnson Foundation (2010) reports that 84% of health care dollars were spent on people with chronic conditions. Spending for someone with five or more chronic conditions was about 14 times greater than for someone with no chronic conditions.

### **Examples of Cost Containment from Wellness/Disease Management Programs**

The Committee reviewed the experience of other employers and learned that:

- King County (Washington) estimates a cumulative savings of \$26 million through its Health Reform Initiative, which reduced the annual growth in health care costs from a projected 11% to 9% between 2005 and 2009. The Health Reform Initiative put in place financial incentives for healthy behaviors.
- Johnson & Johnson estimates that its employee health and wellness efforts improved productivity and reduced health costs by \$400 per employee (2007). The company estimates its return on investment is \$2.71 for every dollar spent.
- Highmark Healthcare reports \$1.3 million in savings from a wellness effort that had \$808K in expenses (2008). A 2011 report estimated that health care costs increased at a 15% slower rate for employees who participated in the wellness program.
- A pilot project implemented by Boeing during 2006-2009 was estimated to reduce health care costs for people with chronic conditions by 20%. The program provided nurse case managers for 740 employees and dependents.
- Maryland's P-3 program engaged pharmacists to help reduce the cost of diabetes care. Two participating employers documented respective annual savings of \$109K and \$56K.

### **Wellness Programs – Goal and Recommendations**

The Wellness Committee identified the following goal regarding agency wellness programs:

**All five agencies should develop and implement agency wellness programs working within the collective bargaining process as applicable. Employees should take an active role in their health by partnering with their employer in managing and monitoring their health outcomes.**

In addition, the Wellness Committee offers the following recommendations and comments:

1. Agencies should create and foster an organizational culture about wellness and ensure that management is providing leadership in this area. Each agency should establish a health and wellness workgroup (that includes represented employees, non-represented employees, and employer representatives) and should have an individual who has primary responsibility for developing and implementing the wellness program.
2. Agency wellness programs should have goals, outcomes, and incentives in order to increase participation. The Wellness Committee agrees that inter-agency aggregate data collection and analysis should serve as the foundation for designing effective wellness and disease management efforts. (See recommendation from Consolidation Committee.)
3. Agency wellness programs should consider addressing a broad range of issues including exercise/activity levels, weight, smoking, nutrition, and short-term mental health supports like those provided through employee assistance programs.
4. Increasing employee awareness through ongoing communication and reinforcement of the goals and availability of wellness programs is critical.
5. Health risk assessments may be an important tool for employee wellness programs, but there are many outstanding questions that must be answered before any decision is made whether or how they should be implemented.
6. Agencies should review the standards used by accreditation organizations (such as the National Council on Quality Assurance) to help in the development of employee wellness programs or the selection of health plans that will improve health outcomes.

### **Disease Management Programs – Goal and Recommendations**

The Wellness Committee identified the following goal regarding disease management programs:

**The agencies should enhance current disease management programs to increase participation, make sure they are based on best practices, and have regular reporting on outcomes in order to improve the health of employees, spouses/partners, and dependents who have one or more chronic diseases and reduce the number of employees that develop chronic diseases in the future.**

The Wellness Committee believes that the County and bi-County agencies have an opportunity to create an innovative health care delivery system for its employees and their dependents. Toward this end, the Committee recommends that the agencies:

1. Expand the current conversation about disease management to include not only members and plan providers but also doctors, hospitals, and pharmacy benefit managers.
2. Explore value-based purchasing or contracting that moves away from a simple fee-for-service model; work with practitioner networks to reward outcomes; and expand the availability of care management models.
3. Pilot a program wherein health insurance contracting focuses on wellness and aggressive disease management.
4. Offer incentives to increase participation in disease management programs.
5. Explore carving disease management out of health plan contracts so that proposals can be entertained from a range of vendors, not just health plan providers.

## RECOMMENDATIONS AND COMMENTS FROM THE CONSOLIDATION COMMITTEE

The Consolidation Committee discussed different ways to consolidate health benefit practices across agency lines. Consolidated approaches can include: information sharing, data collection and analysis, purchasing, budgeting, and/or administration. Committee members concluded that consolidation could take many different forms, and also that administrative consolidation alone would yield extremely modest savings within the context of total plan costs.

The Committee learned that for over 20 years, the County and bi-County agencies have used a cooperative joint competitive bid process for selecting vendors to administer their group insurance programs. The agencies use a single coordinated request for proposals process for each type of group insurance, e.g., medical, prescription, dental, vision. As part of the joint procurement, vendors bid on administering each agency's existing plan design and level of benefits. In addition, vendors are asked to view the agencies as a single entity for the purpose of proposing fixed administrative fees and plan costs.

Historically, the joint bid process allowed, but did not require, the agencies to make uniform decisions about vendor selection. More recently the agencies agreed to make uniform decisions where possible, in order to capture savings from economies of scale. In particular, the joint bid process has led to administrative savings in prescription drug coverage, where the agencies selected a uniform vendor arrangement despite having different prescription drug plan designs.

**The Committee recommends establishing a focal point for inter-agency data collection and analysis of health care costs, to include understanding of aggregate cost trends and cost drivers.** Centralized data collection and analysis can increase the collective knowledge about health benefit needs and costs. In turn, this should enhance the capacity for the agencies to review best practices and strategize how to collectively contain costs and improve outcomes.

### Potential Advantages and Drawbacks of Consolidation

The Consolidation Committee reviewed potential advantages of the different forms of consolidation. Certain types of consolidation, for example, hold the potential to:

1. Facilitate data collection and analysis across the entire population of covered lives.
2. Increase the agencies' leverage/negotiating power in the health insurance market.
3. Maximize economies of scale through consolidated planning, administration, purchasing, and/or plan design.
4. Maximize the efficiency and return from investment that results from the design and implementation of various initiatives (such as value-based contracting, disease management programs) uniformly and once as opposed to five times.

The Consolidation Committee also reviewed the potential disadvantages of different forms of consolidation. The specific drawbacks discussed included:

1. Consolidation per se does not guarantee lower costs, particularly in a self-insured environment. The savings from administrative consolidation alone would not be material.
2. Consolidation would alter current group insurance decision-making structures, which carries implications for agency autonomy and current collective bargaining practices.
3. Consolidation could disrupt current health plan offerings to employees and retirees.
4. Consolidation would likely require an upfront investment, (e.g., to collect data; to design compatible IT systems), before yielding positive returns over time.



## Consolidated Insurance Programs/Consortiums in Other Jurisdictions

The Committee reviewed examples of consortiums and consolidated multi-agency health insurance programs in other places: Monterey County, CA; Baltimore County MD; Tompkins County, NY; and the County Employee Benefits Consortium of Ohio. This review showed that:

- There are varying models of consolidated public sector health insurance programs.
- The most common reasons cited for consolidating health insurance programs are to achieve economies of scale and mitigate increases in health insurance costs.
- Many consolidated multi-agency programs are governed by a Board of Directors with both agency and employee/union representation.
- The consolidation process is neither simple nor quick. Experience elsewhere shows that consolidation takes a substantial commitment of time and effort from all participants.
- A realistic implementation timeline and effective communication among all affected parties are integral components for a successful consolidation.

In Baltimore County, group insurance plan design and procurement is consolidated among agencies in the County Government's Division of Insurance. The other County agencies (including Baltimore County schools) adopt the common plan options but continue to collectively bargain the premium cost share with their respective employee groups.

## Criteria for Examining Consolidation Options

The Committee recommends the Council establish criteria for examining any potential consolidation options. Suggested criteria include the extent to which any proposed option:

- Assures quality of care for all participants.
- Addresses issues of agency autonomy and impact on collective bargaining.
- Maximizes incentives for cost containment and transparency.
- Minimizes cost increases, plan disruption, and implementation impediments.
- Minimizes creating a situation where the agencies are "captive" to any one provider.

## Issues for Further Study

**The Committee recommends the Council keep in mind that there are no magic bullets to cost savings in health care, and that any improvements will be incremental.** The Committee identified a number of issues for the Council to consider for further study:

- Whether to consolidate some or all plan offerings among the agencies.
- Whether to consolidate design and purchasing of wellness/disease management programs.
- Whether to consolidate purchasing for certain kinds of plans (e.g., HMO, POS) in a single vendor as a way to maximize savings from care coordination and increased use of disease prevention and management.
- Whether to establish a standard "core" benefit package for all agencies.
- Whether to evaluate the role and costs of the Third Party Administrator(s).
- Whether to consolidate staffing and administrative functions.
- Whether to consolidate budgeting for health care benefits.

## ADDITIONAL BACKGROUND INFORMATION

**Information Reviewed by the Task Force.** The Task Force received written information and multiple presentations on a wide range of issues related to the costs and structure of health benefits, wellness, disease management, and value-based plan design. Presenters included members of the Task Force, AON-Hewitt, Dr. Thomas Sawyer, Dr. Paul Fronstin, Ms. Laura Walsh, representatives from Kaiser Permanente, Assistant Chief Administrative Officer Fariba Kassiri, and staff from the Office of Legislative Oversight.

For an online copy of the complete Task Force report and the written material provided to the Task Force, follow the link to the Wellness and Group Insurance Task Force listed on the Council's home page ([www.montgomerycountymd.gov/council](http://www.montgomerycountymd.gov/council)).

**Role of Collective Bargaining.** The role of collective bargaining in the implementation of any Task Force recommendation is a decision to be made by the agencies and the Council. The Task Force acknowledges that changes to employee health benefits must be implemented through the applicable collective bargaining law and process.

**The County and Bi-County Agencies Provide Health Care Benefits to Over 100,000 Enrolled Members.** When one counts enrolled employees and retirees, their spouses/partners, and dependents, the County and bi-County agencies are providing health benefits to more than 100,000 people. (For the bi-County agencies, group health insurance is not procured separately for Montgomery vs. Prince George's County employees and retirees.)

Task Force members commented that such a large number of lives shows the buying power the agencies should be able to leverage when procuring group health services both in terms of costs from economies of scale and in requiring improved quality and health outcomes. The Task Force urges the Council to begin reviewing information on the total number of lives covered across all agencies when discussing how best to provide and fund health benefits.

For the two largest agencies, MCPS and County Government, the total group insurance expenditures for lives associated with active employees and retirees in FY12 (i.e., the cost of actual health care claims and administration) are projected to be \$537 million.

**AON-Hewitt – Overview of Programs Offered by Montgomery County Agencies.** As background for the Task Force's work, AON-Hewitt provided a report comparing major provisions and benefits of current plans. (See Appendix B for a copy of the full report.)

AON-Hewitt provided a comparison of per member or life covered (not just per employee) costs for MCPS and County Government associated with active employees. AON-Hewitt found that when averaged out over all lives covered (associated with active employees), the annual amount spent per person is almost the same. Further, AON-Hewitt concluded that the difference in premium costs for active employees in the two agencies is because County Government includes retirees with active employees in its pool for rate-setting while MCPS separates active employees and retirees into separate pools.

Note: Similar information comparing per member costs for Montgomery County and MCPS retirees and for active and retired employees in the other agencies (Montgomery College, M-NCPPC, and WSSC) has been requested and will be made available before this report goes to worksession.

## Task Force on Employee Wellness and Consolidation of Agency Group Insurance Programs

December 2, 2011

### Appendices

<b>A</b>	<b>Task Force Background Material</b> <ul style="list-style-type: none"><li>• Resolution 17-107, Task Force on Employee Wellness and Consolidation of Agency Group Insurance Programs</li><li>• List of Task Force Participants by Subcommittee</li></ul>
<b>B</b>	Full Report by Aon Hewitt Health and Benefits Consulting: "Overview of Programs Offered by Montgomery County Agencies." October 17, 20011; Revised November 21, 2011
<b>C</b>	<b>July 21, 2011 Meeting</b> <ul style="list-style-type: none"><li>• July 21 Meeting Agenda and Attached Background Information</li><li>• July 21 Meeting Minutes</li></ul>
<b>D</b>	<b>September 6, 2011 Meeting</b> <ul style="list-style-type: none"><li>• September 6 Meeting Agenda</li><li>• Presentation by Office of Legislative Oversight: "Task Force on Employee Wellness and Consolidation of Agency Group Insurance Programs."</li><li>• Presentation by Montgomery County Government: "Overview of Insurance Participant Demographics, Plan Offerings, and Wellness/Disease Management Efforts."</li><li>• Presentation by Maryland National Capital Park and Planning Commission Presentation: "Overview of Insurance Participant Demographics, Plan Offerings, and Wellness/Disease Management Efforts."</li><li>• September 6 Meeting Minutes</li></ul>
<b>E</b>	<b>September 13, 2011 Meeting</b> <ul style="list-style-type: none"><li>• September 13 Meeting Agenda</li><li>• Presentation by Montgomery County Public Schools: "Overview of Insurance Participant Demographics, Plan Offerings, and Wellness/Disease Management Efforts."</li><li>• Presentation by Montgomery College: "Overview of Insurance Participant Demographics, Plan Offerings, and Wellness/Disease Management Efforts."</li><li>• September 13 Meeting Minutes</li></ul>

## Task Force on Employee Wellness and Consolidation of Agency Group Insurance Programs

December 2, 2011

### Appendices

<b>F</b>	<b>September 20, 2011 Meeting</b> <ul style="list-style-type: none"><li>• September 20 Meeting Agenda</li><li>• Presentation by Washington Suburban Sanitary Commission: "Overview of Insurance Participant Demographics, Plan Offerings, and Wellness/Disease Management Efforts."</li><li>• September 20 Meeting Minutes</li></ul>
<b>G</b>	<b>September 27, 2011 Meeting</b> <ul style="list-style-type: none"><li>• September 27 Meeting Agenda</li><li>• Presentation by Dr. Tom Sawyer: "Alternatives to Cost Shifting; Managing through Improving Plan Value."</li><li>• Presentation by Aon Hewitt Health and Benefits Consulting: "Overview of Programs Offered by Montgomery County Agencies." Report Available in Appendix B</li><li>• September 27 Meeting Minutes</li></ul>
<b>H</b>	<b>October 4, 2011 Meeting</b> <ul style="list-style-type: none"><li>• October 4 Agenda</li><li>• "Health Care Cost Containment in MCPS" Distributed by Tom Israel, Montgomery County Education Association – where does this go? This is when it was introduced</li><li>• October 4 Meeting Minutes</li></ul>
<b>I</b>	<b>October 11, 2011 Meeting</b> <ul style="list-style-type: none"><li>• October 11 Agenda</li><li>• Presentation by Paul Fronstin, Employee Benefit Research Institute: "What Do We Know About Consumer-Driven Health Plans?"</li><li>• October 11 Meeting Minutes</li></ul>

**Task Force on Employee Wellness and Consolidation of Agency Group Insurance Programs**

**December 2, 2011**

**Appendices**

<b>J</b>	<b>October 18, 2011 Meeting</b> <ul style="list-style-type: none"><li>• October 18 Agenda</li><li>• Presentation Material, Fariba Kassiri, Assistant Chief Administrative Officer: "Overview of Cross-Agency Resource Sharing."</li><li>• Presentation Material, Wes Girling, Montgomery County Department of Human Resources: "Overview of Joint Procurement."</li><li>• Presentation by Laura Walsh, Associated Administrators LLC: "Contracting for Disease Management, Specialty Pharmacy, Step Therapy."</li><li>• Memorandum from Office of Legislative Oversight: "Comparative Information on Public Sector Health Insurance Consortiaums."</li><li>• October 18 Meeting Minutes</li></ul>
<b>K</b>	<b>October 25, 2011 Meeting</b> <ul style="list-style-type: none"><li>• October 25 Agenda</li><li>• Presentation by Kaiser Permanente: "Kaiser Permanente, The Future of Healthcare is Now Open."</li><li>• Kaiser Permanente Follow-Up Material:<ul style="list-style-type: none"><li>○ Demographic Information on Kaiser Membership, Montgomery County, College, MCPS, and WSSC</li><li>○ Powerpoint Presentation "Montgomery County Agencies Doing Business with Kaiser Permanente"</li><li>○ Answers to Questions/Information Requests</li></ul></li><li>• October 25 Meeting Minutes</li></ul>
<b>L</b>	<b>Meeting Agendas from:</b> <ul style="list-style-type: none"><li>• November 1, 2011 Meeting</li><li>• November 8, 2011 Meeting</li><li>• November 15, 2011 Meeting</li><li>• November 29, 2011 Meeting</li></ul>

**Task Force on Employee Wellness and Consolidation of Agency Group Insurance Programs**

**December 2, 2011**

**Appendices**

<b>M</b>	<p><b>Wellness Material</b></p> <ul style="list-style-type: none"><li>• Summary of King County Health Reform Initiative, Prepared from August 2010 Final Health Reform Initiative Measurement and Evaluation Report</li><li>• Summary of Johnson &amp; Johnson Health and Wellness Program, Prepared from May 2002 Article in Journal of Occupational and Environmental Medicine "The Long-Term Impact of Johnson &amp; Johnson's Health and Wellness Program on Employee Health Risks."</li><li>• Summary of Maryland P3 Program, Prepared from January 2008-December 2008 Evaluation of P3 Program completed by Department of Health and Mental Hygiene</li><li>• Summary of National Committee for Quality Assurance Accreditation, Prepared from NCQA Website Accessed October 2011</li></ul>
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## **Section 1**

### **Background to the Work of the Task Force**

Resolution 17-107, which established the Task Force on Employee Wellness and Consolidation of Agency Group Insurance Programs, includes the policy statement, "Access to affordable health care for all employees and all residents of Montgomery County is a primary goal of the Council." The resolution then asks the Task Force to "identify as much cost containment as possible." The Task Force is to address two issues: (1) employee wellness and disease prevention programs, and (2) consolidation of plan design and administration. As allowed by the resolution, the Task Force organized itself into two committees.

The resolution further asks the Task Force to review employee wellness plans currently in place in the agencies, review information on wellness programs in the public and private sector and look at evidence about whether they have reduced costs over time, make recommendations on improvements to agency employee wellness programs, compare the major provisions of the currently offered health plans, make recommendations on how to streamline and reduce the cost of current administration through consolidation, and make recommendations on other cost containment strategies and options. The Task Force understood that it was not in its mission to make recommendations or comments on the issue of employer/employee cost share, which has been the main focus of the "cost shifting" issue over the past year.

### **Information Reviewed by the Task Force**

The Task Force held a kick-off meeting on July 21, 2011 and then met weekly from September 5, 2011 through November 15, 2011 and again on November 29, 2011. The Committee received presentations from each of the agencies as well as from consultants and organizations on issues related to health care cost containment, contracting, consumer-driven health plans, and the advantages of a staff model health maintenance organization. A summary of these presentations is included in Section 4 of this report. Copies of these presentations are included in the appendices to this report.

### **The County and bi-County Agencies Provide Health Care Benefits to Over 100,000 Enrolled Members**

The County and bi-County agencies are providing health benefits to over 100,000 enrolled members when one includes enrolled employees and retirees and their spouses/partners and dependents. (For the bi-County agencies, group health insurance is not procured separately for Montgomery County and Prince George's County employees and retirees.) Task Force members commented that this shows the buying power the agencies should be able to leverage when procuring group health

services, both in terms of costs from economies of scale and in requiring improved quality and health outcomes.

In the past, information provided to the Council has generally discussed the number of employees or retirees enrolled. The Task Force urges the Council to review information on the total number of members covered when it discusses how best to provide and fund health benefits.

<b>MEDICAL BENEFIT for ACTIVE EMPLOYEES</b>	<b>Total Employees Enrolled</b>	<b>Total Covered (Employee and dependents)</b>
County Government	8,187	20,869
MCPS	19,132	49,052
Montgomery College	1,375	3,495
M-NCPPC (Park and Planning)	1,827	5,785
WSSC	1,345	3,497
<b>TOTAL - ALL AGENCIES</b>	<b>31,866</b>	<b>82,698</b>

<b>MEDICAL BENEFIT for RETIREES</b>	<b>Total Enrolled (retiree or surviving spouse)</b>	<b>Total Covered (retiree and dependents)</b>
County Government	4,603	7,642
MCPS	8,307	12,442
Montgomery College	481	568
M-NCPPC (Park and Planning)	863	1,357
WSSC	1,339	2,105
<b>TOTAL - ALL AGENCIES</b>	<b>15,593</b>	<b>24,114</b>

### **Agency Group Health Insurance Budgets for MCPS, County Government and Montgomery College Total \$389 Million in FY12.**

M-NCPPC and WSSC as bi-County agencies do not approve separate budgets for group health insurance for just Montgomery County. However, the approved FY12 budgets for group insurance benefits for MCPS, County Government, and the College show the magnitude of funding that is required. This amount represents the County funding only and does not include the employee or retiree portion of the premium or out-of-pocket expenses incurred by employees or retirees throughout the year.

**FY12 Budget for Active and Retired Employees (in millions)**

	<b>FY12 Active Employees</b>	<b>FY12 Retirees</b>	<b>Total</b>
MCPS	\$215.5	\$48.1	\$263.6
County Government	\$ 76.5	\$32.5	\$109.0
Montgomery College	\$ 13.0	\$ 3.2	\$ 16.2
<b>TOTAL</b>	<b>\$305.0</b>	<b>\$83.8</b>	<b>\$388.8</b>



For the two largest agencies, MCPS and County Government, the total group insurance expenditures for lives associated with active employees and retirees in FY12 (i.e., the cost of actual health care claims and administration) are projected to be \$537 million.

In December 2010, the Office of Legislative Oversight provided the Council with information on the then-current and projected costs of group insurance for active retirees in the tax-supported agencies (WSSC excluded). OLO Report 2011-2 stated that "Over the past ten years (FY02-FY11), total agency spending on group insurance for active employees increased 134%, from \$134.4 million to \$314.6 million. The total costs of group insurance (assuming no change to the current structure) are estimated to increase another 55% to \$486.6 million by FY16."

OLO also said, "Over the past ten years (FY02-FY11), total agency spending on group insurance for retired employees more than doubled from about \$31 million to \$79 million. Absent changes to the current structure, these costs are estimated to increase another 57% to nearly \$124 million by FY16."

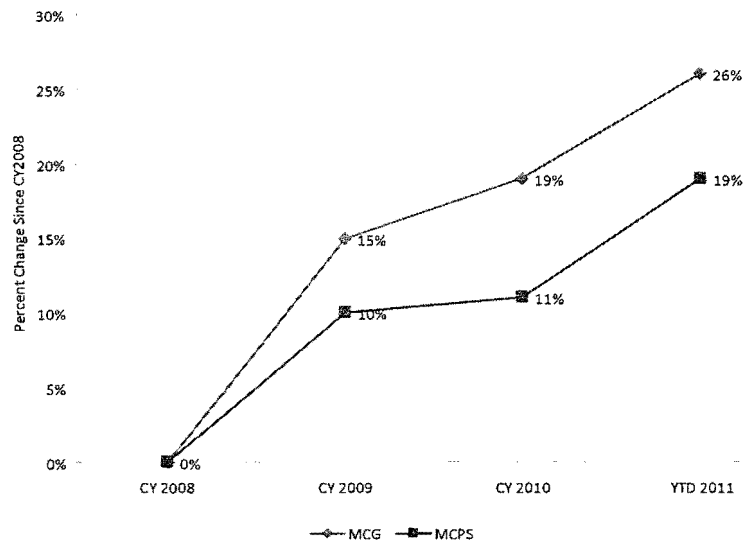
The OLO report included the following information based on 2010 actuarial data, plan designs, and cost share formulas:

	(\$ in millions)			
	FY11 Approved	FY16 Projected*	FY11-FY16 \$ Increase	FY11-FY16 % Increase
<b>Active Employees</b>	<b>\$314.6</b>	<b>\$486.6</b>	<b>\$172.0</b>	<b>55%</b>
<b>Retirees</b>	<b>\$79.0</b>	<b>\$123.7</b>	<b>\$44.7</b>	<b>57%</b>

\*Projected as of December 2010

While the cost of group health insurance is still increasing for calendar year 2012 (which crosses over FY12 and FY13), the Task Force was informed by the agencies that the increase in costs has slowed substantially from what was previously expected. Agencies are expecting 2012 increases of 2% to 5% instead of the 7% to 10% that was expected a year ago. There is no certainty about why this slower than expected growth occurred, it is not unique to Montgomery County, and there is no expectation that it will continue in the long-term. The graph on the following page shows how, for costs associated with active employees, the trend slowed from calendar year 2009 to calendar year 2010. Calendar year 2010 is the primary basis for pricing of 2012 premiums. The graph shows that costs have increased in the first half of calendar year 2011, but until the full year data is available, no conclusion should be made about the growth rate for the year or its implications for premiums in calendar year 2013.

### Health Insurance Claims Trends - Active Employees



Source: Overview of Programs Offered by Montgomery County Agencies, AON Hewitt, November 21, 2011. Prepared for the County Council Task Force on Employee Wellness and Consolidation of Agency Group Insurance, page 20

### AON-Hewitt – Overview of Programs Offered by Montgomery County Agencies

As background for the Task Force's work and in response to the requirement in Resolution 17-107 that the Task Force include in its report a comparison of major provisions and benefits of current plans, AON-Hewitt provided a comparison of plan offerings for the five County and bi-County agencies and an analysis of programs and costs for MCPS and County Government (the two largest consumers of health care benefits). A full copy of this report is included in Appendix B.

For 2012 the agencies are using many of the same medical plan providers. All the agencies use Caremark to administer prescription drug plans. All plans, with the exception of Kaiser, are self-insured. Each of the agencies offers employees a choice in the type of plan provided. Each offers at least one point-of-service (POS) option and at least one health-maintenance-organization (HMO) option. For 2012, Montgomery College will offer a Consumer Driven Health Care Plan (CDHP). They will be the only agency with a CDHP option.

MCPS	Co Govt	M-NCPPC	WSSC	College
United Healthcare	United Healthcare	United Healthcare	United Healthcare	
CareFirst BCBS	CareFirst BCBS			
Kaiser	Kaiser		Kaiser	Kaiser
		CIGNA		CIGNA
Caremark (Drug)	Caremark (Drug)	Caremark (Drug)	Caremark (Drug)	Caremark (Drug)

In 2011, MCPS and WSSC had the highest percentage of employees choosing to enroll in an HMO. MCPS and WSSC have had a lower premium cost to employees enrolled in an HMO. Starting in 2012, County Government will similarly have a lower employee cost share for its HMO plans (5% difference).

**% enrollment by type of plan (2011)**

	POS (or POS/PPO for WSSC and College)	HMO	Indemnity or Supplemental (for Retirees)
MCPS	27%	53%	20%
Co Government	64%	29%	7%
M-NCPPC	47%	40%	13%
WSSC	25%	60%	15%
College	65%	25%	n/a

In terms of the percentage of active employees who opt for employee only, employee+1, or family coverage, Montgomery College has the highest percentage of employee only enrollment. Montgomery College has the highest percentage of family enrollment as well, but this is because they do not offer an employee+1 option.

**% enrollment by level of coverage (Active Employees only - 2011)**

	Employee Only	Employee + 1	Family
MCPS	30%	25%	45%
Co Government	32%	24%	44%
M-NCPPC	37%	25%	39%
WSSC	38%	28%	34%
M College	43%	na	57%

The AON-Hewitt report contains information on plan design features for 2012. AON-Hewitt says, "The POS and HMO plans offered by MCPS and MCG are very comparable since almost all in-network coverage levels are 100% payment after relatively low co-pays of \$5 or \$10." The report notes that MCPS increased its co-pay for emergency room visits to \$100 in order to encourage people to use urgent care centers rather than emergency rooms. MCPS and Montgomery College are not considered "grandfathered plans" and therefore under healthcare reform may not have co-pays for certain preventive services. Generally speaking, co-pays for WSSC and Montgomery College plans are higher than for MCPS and County Government plans.

For those using in-network services in the POS and PPO plans, there are differences in plan design for items such as co-pays and deductibles, with MCPS generally having lower co-pays. Montgomery College is the only agency to have co-insurance for plans for active employees. While all of the agencies use Caremark as their prescription drug administrator, each agency's plan options have different co-pays

and out-of pocket structures. Montgomery College is the only agency to have a co-insurance model for prescription drugs (for their POS and CDHP plans).

The AON-Hewitt report summarizes the employee and retiree cost shares. Note that these are the cost shares for 2012 and reflect the change in County Government to have a higher cost share for non-HMO plans for active employees.

#### Active Employees

	MCPS	Co Govt	M-NCPPC	WSSC	College
HMO	5%	20%	15%	20%	25%
Non-HMO	10%	25%	15%	22%	25%
Rx	10%	25%	15%	20%/22%	25%

#### Retirees

	MCPS*	Co Govt*	M-NCPPC	WSSC	College
HMO	36%	30%	15%	20%	40%
Non-HMO	36%	30%	15%	20%/22%	40%
Rx	36%	30%	15%	20%/22%	40%

\*County Government and MCPS are average cost shares as cost share may be different for some retirees based on years of service.

AON-Hewitt provided two comparisons of per enrolled member (not per employee) costs for MCPS and County Government associated with active employees (not retirees). The first compared the average expense broken down by plan type. The second averaged costs across all plan types.

#### Average expenditure per member by plan type

	MCPS	Co Govt
HMO	\$3,553	\$3,996
POS	\$4,365	\$3,869
Kaiser*	\$4,843	\$4,911

\*Kaiser Rx is included in the average expenditure for Kaiser  
An average of \$1,273 would have to be added to MCPS and \$1,235 to County Government to compare an average total cost by plan type.

#### Average expenditure per member across all plan types

	MCPS	Co Govt
All Medical*	\$4,066	\$4,028
All Rx	\$1,273	\$1,235

\*Kaiser Rx is included in Medical

The tables show that while, on average, MCPS spends less than County Government on a member in an HMO plan, they spend more on a member in a POS

plan. When averaged out over all members covered (associated with active employees) the annual amount spent per member is almost the same.

AON Hewitt states that, "In sum, a detailed comparative analysis indicates that the primary reason behind the differences in premium costs for MCPS and MCG is that MCG includes retirees with active employees in its pool for rate setting while MCPS separates active employees and retirees into separate pools. The other factors have a nominal affect on cost differences."

AON-Hewitt provided the estimated average total premium cost for active employees. MCPS develops active employee premium rates based on claims experience of active employees only. The other agencies blend the claims experience of active and retired employees in setting premium rates. Premium rates are the amount charged per employee to cover expected costs of a specific plan, they are not the average amount spent per employee or the average amount spent per enrolled member (employee, spouse/partner, and dependent.)

Average 2012 Total Premium per Employee (employee and employer share)					
	MCPS	Co Govt	M-NCPPC	WSSC	College
Total	\$13,206	\$15,201	\$13,714	\$15,140	\$10,695

AON-Hewitt also used its actuarial model to give a relative "value" to the plans offered by MCPS and County Government (MCG). AON-Hewitt concludes, "The POS and HMO plans offered by MCPS and MCG are very comparable since almost all in-network coverage levels are 100% payment after relatively low copays of \$5 or \$10. The MCG emergency room copay is much less than MCPS (\$25 vs. \$100). MCPS increased their co-pay in 2011 to incent greater use of urgent care facilities instead of more costly emergency rooms."

### **Role of Collective Bargaining**

Each of the agencies provides group health insurance to represented and non-represented employees.

The Wellness and Consolidation Committees' recommendations and comments do not specifically address whether or how collective bargaining should be a part of the implementation process.

Each of the members from the collective bargaining organizations strongly stated that changes to health benefits must be implemented through the applicable collective bargaining laws and processes. Members also discussed the interests of their organizations in improving health and wellness of their members and containing costs.

The Montgomery County Education Association (MCEA) provided a summary, *Health Care Cost Containment in MCPS*, (Appendix H) that lists changes implemented

over the past ten years to contain costs. MCEA noted that these changes were implemented through the work of the "Joint Employee Benefits Committee" that includes representatives from MCPS administration and MCEA, SEIU Local 500, and MCAAP. Measures include incentives for enrolling in HMOs, incentives for the use of lower cost mail order drugs, disincentive to use of emergency rooms, focusing on reducing high cost claims (more than \$50,000 per year), promoting smoking cessation, and wellness promotion.

MCCEO Local 1994 invited Dr. Thomas Sawyer (MCCEO's health care consultant) to present cost containment recommendations to the Task Force and told the Task Force that MCCEO has been trying to bring these ideas to the table but has not been able to engage County Government in meaningful discussion about wellness and disease management. The Fraternal Order of Police, Lodge 35, stated its position that benefits are a mandatory subject of bargaining, but there are areas of administration and purchasing that can be changed to achieve overall cost savings.

Members representing the collective bargaining organizations emphasized the importance of communication and collaboration and their opposition to change being imposed outside of the collective bargaining process.

Some of the public members provided a different perspective. Collaboration regarding health care benefits currently constitutes discussions among numerous autonomous entities. It is unclear whether this process, which perpetuates fragmentation, maximizes efficiency and effectiveness. While autonomy may serve the interests of the political leadership, the career managers, and the numerous bargaining units, it may not be the most cost effective system for local taxpayers. It was noted in discussion that the existing organizational arrangements should not be fixed in concrete and that, since they were statutorily created, they can be changed in similar fashion.

## Section 2

### **Recommendations and Comments from the Wellness Committee**

The Wellness Committee is providing recommendations and comments around two strategies: (1) **Employee Wellness** programs that are broadly promoted and targeted to keeping healthy people healthy and address health risk factors that have not yet developed into a serious illness, and (2) **Disease management** programs to help employees and dependents with chronic conditions. Disease management is a system of coordinated communication and intervention supports that serves a specific population, includes physicians and other health care providers, uses an evidenced-based plan of care, includes patient self-management education, emphasizes prevention, and measures outcomes. Some of the largest chronic conditions include heart disease, diabetes, Chronic Obstructive Pulmonary Disease (COPD), high cholesterol, and asthma.

There are many reasons why all of the County and bi-County agencies should develop and implement wellness and disease management programs. As employers, every agency should look out for the well-being of its workforce, their spouses/partners, and dependents. There are also very practical reasons. Improved wellness can reduce costs associated with absenteeism (to care both for one's self and for family) and "presenteeism," which is a loss of productivity when employees come to work sick or are trying to manage a family member's illness while still working everyday. Most critically, an increasing number of people have chronic conditions, which is adding significantly to the cost of providing health care. If health care costs are to be contained, not just shifted, then effective wellness and disease management programs must be implemented. There needs to be a concurrent reduction in demand for health services through integrated prevention, risk reduction, and disease management practices.

### **Background – The Impact of Chronic Conditions**

The 2010 Robert Wood Johnson Foundation (RWJ) report, "Chronic Care: Making the Case for Ongoing Care," notes that in 2009, 145 million people lived with a chronic condition. This is 10 million more than the 2009 projection developed in 2002. The percent of all Americans with two or more chronic conditions grew from 24% in 2001 to 28% in 2006. As many as 6% of females and 4% of males have 5 or more chronic conditions. Annual out-of-pocket spending increased by nearly 30% from 2001 to 2006 for those with one or more chronic condition.

Nationally, the RWJ report notes that 84% of 2009 health care dollars were spent on people with chronic conditions. Most people with chronic conditions (78 million) are working age people and 54% of those people have private insurance. These people account for 73% of private insurance spending. Almost all Medicare dollars and about

80% of Medicaid dollars are spent on people with chronic conditions. In 2006, health care spending for someone with one chronic condition was about 3 times greater than for someone without a chronic condition (\$1,081 vs. \$2,844). Spending for someone with five or more chronic conditions was about 14 times greater than for those with no chronic condition (\$14,768 vs. \$1,081).

People with multiple chronic conditions are much more likely to be hospitalized. People without chronic conditions accounted for 4% of people with inpatient hospital stays while people with 5 or more chronic conditions accounted for 27% of people with inpatient hospital stays.

People with no chronic conditions spent an average of \$70 per year on prescriptions compared to \$4,053 per year for people with 5 or more chronic conditions.

A 2010 Issue Brief from the Center for Healthcare Research and Transformation reports that after childbirth, the most common reasons for in-patient hospitalizations are related to cardiovascular disease. It notes that in 2007, heart disease accounted for \$143 billion in national spending, the highest total spending for any condition. "Among the most common reasons for hospitalization are conditions that are defined as 'potentially preventable' – that is, those that may be preventable with high quality primary and preventive care. Thus, higher rates of 'potentially preventable hospitalizations' – including hospitalizations for heart failure and pneumonia – highlight specific areas where targeted improvements can be made."

The March 2011 document "Chronic Disease in Maryland: Facts and Figures" (Department of Health and Mental Hygiene - DHMH) states that "Chronic Disease is the leading cause of death, disability, and health care costs in Maryland." In 2009, heart disease was the leading cause of death in Maryland (25.5% of all deaths) while 37.4% of adults reported high cholesterol and 30.1% of adults reported high blood pressure, both risk factors for heart disease. While diabetes was the 6<sup>th</sup> leading cause of death, it also contributes to death from heart disease, stroke, and kidney disease.

The DHMH report includes information from the World Health Organization that at least 80% of heart disease, stroke, and Type 2 diabetes and 40% of some cancers are preventable through proper nutrition, daily physical activity, and smoking cessation. It also notes that tobacco use is the single most preventable cause of death in the United States and is estimated to cause 80% of COPD.

In terms of cost, the DHMH report notes that in 2007, over \$550 million was spent in Medicaid for prevalent chronic diseases. The Milliken Institute estimated that in 2003 chronic conditions cost the State of Maryland \$5.2 billion in treatment expenditures and \$20.5 billion in lost productivity.



## The 80/20 Rule

The Task Force heard many times from presenters and its own members about the 80/20 rule – that about 80% of health care dollars are spent on 20% of people. While some of the 20% in any given year are people with a high-expense health claim from a serious injury or from complication of childbirth (for mother or baby), most are high-cost, high-risk individuals with more than one chronic condition.

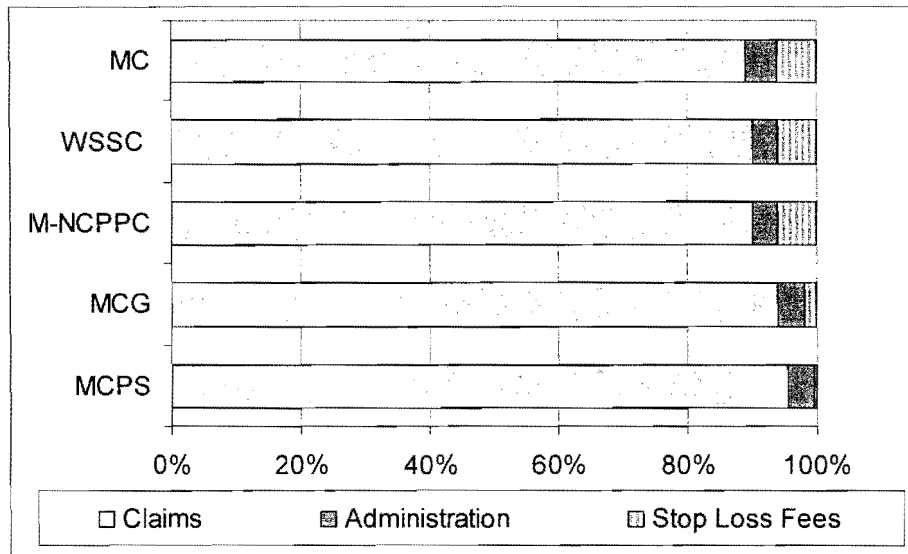
Another way to look at this issue is by reviewing four categories of people, as shown in the following table. The goals of employee wellness and disease management programs are to (1) keep healthy people healthy, (2) find ways to reduce the overuse of health care services (such as the overuse of the MRI when someone has a complaint about back pain), and (3) get those who are sicker than they think to have their conditions identified and managed so that they do not become high-risk.

<b>“Healthy People”</b>  About <b>75%</b> of the population They identify themselves as healthy and their physicians view them as healthy. They have minimal health care costs and average about 3 visits per year.	<b>“Sicker than they think”</b>  About <b>10%</b> of the population These people believe they are healthier than they actually are. Many have unattended chronic conditions. They avoid medical care and average about 5 visits per year.
<b>“Over-users of Medical Services”</b>  About <b>10%</b> of the population These people have complaints about real or perceived illness or injury that end up over-using medical resources. They have unnecessary health care costs and average almost 10 visits per year.	<b>“High-Risk”</b>  About <b>5%</b> of the population Multiple chronic health conditions that have high costs and increased chance of hospitalization. They average about 9½ visits per year.

Adapted from polakoff/boland and EpsteinBeckerGreen (data from Predictive Health 2005, 2011)

## The Rising Cost of Health Care Claims Can Be Reduced by Wellness and Disease Management Programs

This Task Force was asked to look for cost containment and cost savings through consolidation and improved employee wellness. While there are many lenses to look through for containing the growth in health care costs, what is clear is that to have significant and sustained savings, spending for health care claims must be impacted. MCPS and County Government, which account for most of the health care spending, spend only 4½% to 6% on plan administration and stop loss fees; 94% of County Government spending and 95.5% of MCPS spending is for medical claims.



One way to reduce the cost of health care claims is for the plans to negotiate lower reimbursements for a fee-for-service, but this does nothing to stop the inefficient or ineffective use of medical services. In the long-term, improving people's health and wellness is the most effective way to impact total spending on health care.

This report will later discuss in more detail initiatives that have been shown to reduce the increase in health care spending. They are generally structured, multi-year efforts. In terms of estimated savings:

- King County (Washington) estimates that it saved \$26 million from 2005 to 2009 through its Health Reform Initiative by "bending the trend on health care expenses" from a projected 11% per year to 9%. The Health Reform Initiative put in place financial incentives for healthy behaviors. Since 2009, additional savings have been realized from increased use of generic drugs and an increase in the percent of employees enrolling in a less costly health plan that emphasizes preventive care and evidenced-based medicine.
- Johnson & Johnson has a long-standing employee health and wellness effort and estimates that it has helped to reduce their per-capita health plan costs by \$400 per employee (2007) and has significantly improved productivity. In 2002, it was estimated that Johnson & Johnson was saving about \$8.8 million annually and a 2010 Harvard Business Review article says that Johnson & Johnson estimates their return on investment is \$2.71 for every dollar spent.
- A 2008 study estimated that over four years Highmark Healthcare achieved \$1.335 million in savings from a wellness effort that had \$808,000 in expenses, a return on investment of \$1.65 for every dollar spent on the program. A 2011 report estimated that health care costs at Highmark rose at a 15% slower rate for employees who participated in the wellness program.

- A pilot project implemented at Boeing during 2006-2009 was estimated to reduce health care costs for people with chronic conditions by 20%. The program provided nurse case managers for 740 employees and dependents. Savings were estimated to come primarily from a reduction in emergency room visits and hospitalizations.

Information presented by Kaiser Permanente to the Task Force discussed the importance of following medical best practices for managing chronic disease. For example, prescribing aspirin and blood pressure and cholesterol medication to people over the age of 55 with diabetes or hypertension can prevent heart attack and stroke. Studies show that it costs \$10,113 to treat 57 people with these medications, but this would prevent one heart attack that costs \$33,740. This is a 333% return on investment.

### **Efforts Must Be Evaluated**

The Committee's recommendations for both wellness and disease management programs emphasize the need for outcomes. This implies that there must also be the resources to evaluate efforts to determine if goals are being reached and if savings are being realized. In 2007, the Wellness Councils of America highlighted the following reasons about why evaluation is important:

- To obtain feedback so that you can improve your programming efforts;
- To demonstrate the value of your program;
- To measure change;
- To secure continued funding;
- To establish accountability; and
- To compare the efficacy of different interventions.

Oversight and evaluation require regular **cross-agency data and analysis of health care trends for enrolled members**. While each of the agencies provided data on their organization and the Task Force was able to review the AON-Hewitt cross-agency report, the Task Force was not able to review a cross-agency utilization report that would provide a baseline for recommending or evaluating specific changes. A long-term wellness and disease management effort will require that cross-agency data be readily available. The Consolidation Committee recommends improved data as one of its preliminary conclusions about consolidation.

## **Employee Wellness Programs**

### **Overall Goal**

**All five agencies should develop and implement employee wellness programs, working within the collective bargaining process as applicable. Employees should take an active role in their health by partnering with their employer in management and monitoring of their health outcomes. While any plan for employee wellness may begin by focusing on employees, long-term plans should look at ways to include employees, retirees, their spouses/partners, and dependents.**

### **Background**

As a part of the initial agency presentations to the Task Force, each agency representative was asked to give an overview of their wellness program. While each agency has access to programs offered through the medical insurance providers, there are currently very different levels of effort regarding employee wellness. MCPS, Montgomery College, and WSSC have the most organized efforts.

### ***Montgomery County Public Schools***

- MCPS initiated a joint wellness program in 2009 when the Joint Workgroup on Health Care Cost Containment and Employee Wellness looked at data showing that about \$36 million in health care costs were due to asthma, diabetes, obesity, and cardiovascular disease – all preventable and/or manageable.
- In the fall of 2010 MCPS implemented the “Well Aware” program that includes “MCPS on the Move” activities. The MCPS on the Move effort was available to 10,000 employees and 5,300 participated. Outcomes included 103,000 hours of logged activity and weight loss of 16,490 pounds. Average body mass index (BMI) started at 26.2 and ended at 22.4, moving the group from the obese category to the normal weight category.
- MCPS has a full-time Wellness Coordinator to work on enhancing and expanding efforts to all employees.
- MCPS and Kaiser have partnered to offer an 8-week smoking cessation program that will include group support. The program is available to Kaiser and non-Kaiser members. There will be an evaluation to determine if the program is successful.

## ***Montgomery College***

- The College runs several competition-based wellness programs each year, most around increased activity such as walking.
- The College has a full-time Wellness Coordinator to assist with rolling these programs out to all employees.
- The College has an advantage as it has on-site athletic and fitness facilities that can be used by faculty and staff.
- The College offers up to 1½ hours of “release time” weekly that is matched by staff employees’ time to provide extra flexibility for opportunities such as lunch-time workouts.

## ***Washington Suburban Sanitary Commission***

- WSSC has an Employee Development Group and holds a Wellness Fair as a part of Open Enrollment. WSSC is emphasizing the theme “eating well, being well, staying well.”
- There are ongoing programs such as “Lunch N Learn” and “Morning Wellness Sessions at the Depot.”
- For the coming year, the Employee Development Committee is considering a variety of wellness sessions in the areas of exercise and fitness, heart health, and men’s health.

## **Recommendations and Comments**

### **1. Create an organizational culture about wellness and make sure that management is providing leadership in this area.**

The Wellness Committee agrees that this is the key to an effective program. There must be buy-in at the highest level, and employees must feel that their efforts to improve their health are supported.

Studies show that the views of management are critical to the effectiveness of wellness programs. For example, the 2010 evaluation report for the King County (Washington) Health Reform Initiative included in its five key recommendations the need to “reinvigorate leadership investment in creating a healthy workplace culture. Individual healthy behaviors thrive when change is supported and rewarded.” The King County Health Reform Initiative was based in part on the understanding that the program would not be successful unless there was a very high level of participation (90% to 95%). After four years, a survey found that 89% of employees still rated the importance of reducing health risks and maintaining healthy habits as a 4 or 5 on a

scale of 1 to 5. However, the evaluation showed that management support slipped after a couple of years.

Johnson & Johnson, which has had a long standing employee health and wellness program, emphasizes the importance of participation and support by the entire organization. (Additional discussion of Johnson & Johnson and King County is included in the discussion of disease management on pages 21-22.)

In March 2011, Mercer and the Health Enhancement Research Organization (HERO) released information from their Employee Health Management Best Practices Scorecard that concluded that organizations with senior management commitment to wellness have higher participation rates for health management programs. For example, 53% of employees in organizations with strong leadership took advantage of biometric screening programs versus 38% for organizations reporting little or no organizational support.

In its overview presentation to the Task Force, WSSC commented how important it is for managers to support employee efforts to improve wellness. If job coverage needs minor adjustments to allow people to attend appropriate activities, it is important that employees know that managers support this. Montgomery College noted that they are able to provide some flextime to staff to fit work-outs or other wellness activities into their schedules. This sends a message that the organization supports employee health.

As a part of this recommendation, **the Wellness Committee recommends that each of the agencies establish a health and wellness workgroup that includes represented employees, non-represented employees, and employer representatives.** The agencies have varying levels of this in place already, but the Wellness Committee believes that dialogue is important to developing an organizational culture around wellness. The Committee discussed MCPS' Joint Employee Benefits Committee, which has been meeting for 10 years to discuss a range of issues and proposals including cost containment measures and wellness efforts. Montgomery College also meets with its union representatives in a joint work group to review benefit issues. Park and Planning has an employee council that looks at developing wellness programs that are offered through the year. Representatives from the Montgomery County Government Employees' Organization Local 1994 (MCGEO) and the International Association of Fire Fighters Local 1664 (IAFF) said that the County Government unions all would like to have employee health committees but they have not yet been successfully established. The Wellness Committee is not recommending how the agencies might or might not work with these workgroups in the collective bargaining process, rather that regular joint dialogue about trends in employee health care needs, claims, and costs creates trust and a common understanding about efforts to improve health and wellness.

**Lastly, the Wellness Committee agrees that creating a strong organizational culture around wellness requires investment. Each of the**

**agencies should have an individual who has primary responsibility for developing and implementing the wellness program.**

**2. Employee wellness programs should have goals, outcomes, and incentives in order to increase participation.**

The Wellness Committee had significant discussion about the need to find ways to increase participation in voluntary employee wellness programs. MCPS was pleased that about half of the 10,000 employees eligible for the original rollout of the “Well Aware” program participated but wants to find ways to engage the other half.

MCPS and the College have kept data regarding outcomes for some of the programs they have implemented. Some of these are activity-based, such as logging hours of activity, and some are results-based, such as weight loss and reduction in body-mass index. As programs are increased, the agencies should collect outcome data so that programs can be evaluated.

The Wellness Committee also discussed the potential long-term savings that could occur if the MCPS/Kaiser smoking cessation program is filled and is shown to be effective. MCPS expects there will be a substantial return on investment for this program as Kaiser estimates that a smoker’s annual health care costs are \$3,400 more per year than a non-smoker’s. The first class has room for 25 participants. Reducing the number of employees and spouses/partners and dependents who smoke could reduce health care costs in the long term.

MCPS and the College noted that relatively small incentives such as gift cards can really increase the interest and participation in employee wellness programs. Agency funding of these types of incentives should be looked at in a positive manner if they improve outcomes. The issue of incentives can also be an important tool to increasing participation in disease management programs. Examples of these types of incentives will be noted in the recommendations and comments on disease management.

**3. Employee wellness should look at a broad range of issues, including exercise/activity levels, weight, smoking, nutrition, and short-term mental health supports like those provided through employee assistance programs.**

Efforts to increase wellness should look at a broad range of opportunities including improved access to gyms and county facilities (there are some discounts to private facilities already available through the health plans) and changes to food in vending machines, cafeterias, and at meetings.

#### **4. Increasing employee awareness through ongoing communication and reinforcement of the goals and availability of wellness programs is critical.**

The agencies currently have different amounts and types of communication with employees. Not all the agencies have the same level of regular, easy to access information, updates, and newsletters about health and wellness. Both MCPS (Well Aware) and Montgomery College (Wellness Connection) have easily found, well-developed information on their websites. For the other agencies, wellness offerings can be found in information on overall benefits and employee assistance programs. Regular communications through newsletters (which can be electronic) and e-mail updates can help build the organizational culture that is the #1 recommendation of the Wellness Committee.

#### **5. Health risk assessments may be an important tool for employee wellness programs, but there are many outstanding questions that must be answered before any decision is made whether or how they should be implemented.**

The health risk assessment (HRA) typically serves as a core measurement and intervention tool when combined with appropriate follow-up and referral. The primary goals of an HRA are to: 1) raise employee awareness, 2) motivate employees to seek appropriate interventions and reinforce progress through follow-up assessments, 3) identify the distribution of risk (e.g., percentage of low-risk and high-risk employees) across the population, and 4) serve as a benchmarking, planning, and evaluation tool. HRAs are currently a very popular tool for obtaining baseline information and identifying health risks that might be addressed through wellness or disease management programs. Emerging evidence shows that to be most effective, HRAs should include health coaching (face-to-face, telephonic, and/or Internet) to reinforce healthful behavior change. However, the Wellness Committee believes that the agencies must address several questions before they consider implementing them. The key question is "What is the purpose of the health risk assessment?" With regard to voluntary employee wellness activities like those being addressed in this section, is an HRA necessary, or should just the health information associated with the goals of the activity (such as having weigh-ins for weight loss programs) be obtained?

Most often, an HRA is a self-reporting survey tool. The Wellness Committee questions whether this is the best tool for identifying health risks and making sure that the health information is accurate. For example, would a better investment be to provide incentives to employees and their spouse/partner and dependents to have an annual physical that would include certain health care screenings? It was noted that under the federal health care reform law, certain preventive services must be offered without a co-pay, and for the "grandfathered" plans, co-pays for physicals are already generally very small.

If a self-reporting tool is used, it must be clear who will have access to the information, what information is confidential and HIPAA protected, and how information



will be used. If the health assessment is done through an annual physical, then the information would be handled by the health care practice and the health plan as it is now. Aggregated information can be provided by the health plan to the agencies for use in evaluation and oversight. Communication about the goals of an HRA or annual physical must occur as there must be trust between the agency and the employee about how health information will be used.

The use of the HRA as part of an overall program that is structured on incentives and interventions will be discussed further as a part of disease management.

**6. The agencies should review the standards that are used by accreditation organizations like the National Council on Quality Assurance (NCQA) to see if they can help in the development of employee wellness programs or the selection of health plans that will improve health outcomes.**

The Wellness Committee is not recommending accreditation but discussed that accreditation standards do focus on best practices and performance measures. The Wellness Committee did not think that accreditation should be a goal for wellness programs or necessarily be a requirement for medical plan providers. However, there may be value in reviewing the requirements for accreditation for employee wellness programs and discussing which of these standards might help the agencies develop better and more effective wellness programs.

Standards are a critical issue to disease management and value-based purchasing, which is addressed in the next series of recommendations on disease management programs.

## **Disease Management Programs**

### **Overall Goal**

**The agencies should enhance current disease management programs to increase participation, make sure they are based on best practices, and have regular reporting on outcomes in order to improve the health of employees, spouses/partners, and dependents with one or more chronic conditions and reduce the number of employees who develop chronic diseases in the future.**

### **Background**

All the agencies currently contract with the health insurance companies for disease management programs that are available to the plan's members. Chronic conditions that are usually covered include: asthma, coronary artery disease, chronic obstructive pulmonary disease (COPD), congestive heart failure, diabetes, heart failure, and lower back pain.

In these programs, the plan is responsible for identifying patients who have been diagnosed with one or more chronic conditions. There is then outreach through the mail or by phone to determine what kind of support might help the patient manage their condition(s). Participation in these programs is voluntary. The agencies receive information from the plan providers on utilization and patient compliance with medication use and care coordination.

As part of the agency overview presentations, Montgomery College noted that for their plan offered through CIGNA:

- 53% of all identified individuals are participating in the disease management program; 32% of those participating are engaged by telephone.
- 56% of engaged individuals have an acute or high need.
- The diabetes program has the greatest number participating.
- The lower back pain program has the greatest number of people that opt out.
- CIGNA estimates that the program generated \$200,000 in savings.

Park and Planning noted that the disease management plan offered through United Healthcare:

- Offers behavioral health and co-morbidity management based on national guidelines.
- Works to reduce variation in clinical quality and cost management by improving patient self-management and providing guidance to designated physicians and networks.
- Focuses on members who have a significant impact on medical spending.

The full Task Force received a presentation from Kaiser Permanente, which is a staff-model Health Maintenance Organization (HMO). Kaiser does not have a separate disease management program because prevention and disease management are integrated into their model. Kaiser said that their comprehensive electronic medical records, emphasis on prevention, standards around best practices, and ability to communicate in multiple ways with doctors and other Kaiser health care professionals provide an effective disease management model.

The Task Force also received a presentation from Ms. Laura Walsh, CEO of Associated Administrators LLC, on contracting for disease management. Ms. Walsh discussed some of the requirements that should be included if one is contracting for an outside disease management firm (as opposed to using the programs offered by the medical plan). These must include clarity for responsibilities, HIPAA protections, types of outreach services, performance metrics, regular reporting to those responsible for the plan, audit rights, any requirement for return-on-investment (ROI), and whether the program is voluntary or mandatory. She said that "disease management programs are generally well received by the participant, but, ironically, poorly utilized."

In addition to the information provided to the Task Force, the Wellness Committee reviewed information on the Johnson & Johnson Health and Wellness Program, the King County Health Reform Initiative, and the Maryland P-3 Program. The following provides some summary points about each program. Additional information is included in Appendix M.

### **A. Johnson & Johnson Health and Wellness Program**

Johnson & Johnson introduced the “Live for Life” program in 1979. The purpose of the program was to make Johnson & Johnson employees the healthiest in the world. Johnson & Johnson regularly evaluated its program.

The program underwent revisions and in 1993 and was recast as “Johnson & Johnson Health and Wellness Program (HWP).” Integrated health, wellness, disability management, employee assistance, and occupational medical were included. The goal is to reduce individual behavioral and psychosocial risk factors before they are transformed into disease and disability.

There is a financial incentive for employees. A 2002 evaluation noted that a \$500 medical benefit plan credit was given to those who completed the health risk assessment and participated in recommended high-risk intervention programs (named Pathways to Change). People with borderline risks received targeted mailings and low-risk employees received general health education materials. It is participation in the risk assessment and intervention program that made the employee eligible for the credit, not the outcome from participation. The financial incentive and corporate culture result in 90% of the domestic US employees participating (about 43,000 employees).

The risk areas targeted are: nutrition, aerobic exercise, tobacco use, motor vehicle safety, blood pressure, cholesterol, body composition, and diabetes.

A review of data from 1995 to 1999 showed there were statistically significant changes for 8 of 13 risk factors for Health and Wellness Program participants. However, the program was not successful in reducing risk factors associated with increased age: high body weight, risk for diabetes, and a high fat diet.

Important lessons from this effort include the positive impact on all employees who participated in the Health and Wellness Program whether they participated in the Pathways to Change programs or not, and evidence that demonstrates that a complex, large scale health management program can be implemented in a large corporation and have a very high participation rate.

### **B. King County (Washington) Health Reform Initiative**

The King County Health Reform Initiative (HRI) was launched in 2005. The HRI has 3 goals: (1) improve the health of employees and their families; (2) reduce the rate of cost increase for health care; and (3) determine whether employee productivity

increased as a result of improvements in health. The third goal was added in 2007. The HRI required evaluation and peer review.

The 2010 Final Evaluation Report notes that King County negotiates with 92 bargaining units. "The county and unions started the HRI with an emphasis on improving health behaviors with the intention to change plan design to encourage the use of higher value care and discourage the use of lower value care as shared tools and information on cost and quality became more available."

Health care costs were rising at 3 times the CPI when the HRI was enacted. Five percent of all people covered accounted for 58% of costs. Low back pain, cancer, depression, diabetes, coronary artery disease, and asthma were the most costly conditions, and high cholesterol and high blood pressure were the most common risk factors.

Fourteen percent (14%) of people covered had five or more chronic conditions. For each chronic condition a person had, it was estimated that the cost of health care doubled.

The HRI has a Wellness Assessment and an Individual Action Plan component. There are financial incentives for employees and their spouses/domestic partners to complete the assessment and participate in the Individual Action Plans. Incentives are structured through three cost tiers for health insurance: Bronze (does not take health assessment or participate in action plan), Silver (takes health assessment, does not participate in action plan), and Gold (takes assessment and participates in action plan). There is no employee cost share for the premium, but there are significant differences for deductibles, co-insurance, and co-pays. For example, the annual deductible for a family in the "Gold" plan is \$300 compared to \$1,500 for the "Bronze" plan, and the hospital co-pay for Gold plan is \$200 compared to \$600 for the Bronze plan. The overall structure of the program has resulted in a participation rate of about 90% for completing the wellness assessment and between 80% and 90% for completing action plans.

From 2006 to 2009, employees and spouses/domestic partners showed improvement in 12 of 14 health-related behaviors and risk factors as measured in the health risk assessment. For two measures, physical activity and blood glucose, the changes were not significant.

In 2010, funding for the HRI will cost \$16.71 per month per person for contribution to the Puget Sound Health Alliance, workplace health promotion, and benefit plan design.

King County estimates that the HRI has saved \$26 million when comparing actual cost increases to cost increases that were projected before the HRI was implemented.

### **C. Maryland P-3 Patients Pharmacists Partnership (P-3) Program**

The Maryland Patients Pharmacists Partnership (P-3) Program was designed in 2006 to reduce employee and employer costs by eliminating obstacles to diabetes care and improving overall health outcomes.

Pharmacist-coaches from Maryland Pharmacist Association and University of Maryland use best practice guidelines to provide patient-centered care to promote medication adherence, lifestyle changes, and improve disease self-management knowledge.

In 2008, the P-3 Program served 225 employees at four employer sites in Alleghany County, Frederick County, Howard County, and Baltimore City. There were 138 trained pharmacists in 2008, but 30 provided direct care to patients during the evaluation period. Employers were responsible for enrolling participants, sharing data from third party administrators and pharmacy benefits managers, and making payments to pharmacists providing services.

Evaluation compared P-3 participants at the end of the program with comparison groups from the Health Plan Employer Data and Information Set (HEDIS). It shows that 9.1% of P-3 patients had poor control of HbA1c levels at the end of the year compared to 30% of diabetes patients in Maryland commercial insurance plans and 45.9% of those in Maryland Medicaid. Slightly more than half of P-3 patients met their therapeutic goals.

With regard to cholesterol, 39.4% of P-3 patients had LDL levels of less than 100 mg/dl compared to 46% of diabetes patients in Maryland commercial insurance plans and 35.4% in Maryland Medicaid. Blood pressure readings showed that 71% of P3 patients had blood pressure below 140/90 mmHg compared to 56% of diabetes patients in Maryland commercial insurance plans and 51% in Maryland Medicaid.

Two participating employers documented savings of \$109,112 and \$56,120 respectively.

### **Recommendations and Comments**

**1. The agencies should expand the current conversation about disease management to include not only members and plan providers but also doctors, hospitals, and pharmacists.**

Preventive healthcare and disease management must be improved if trends in county health care cost are to be contained. The county has significant buying power (over 100,000 enrolled members) and should use its buying power to change contracting so that vendors have "more skin in the game."

**2. The agencies should explore value-based purchasing or contracting that moves away from a simple fee-for-service model, working with practitioner networks to find ways to reward outcomes and expand the range of care management models.**

There may need to be incentives to practitioners for improved care management. While Montgomery County employees do not all live in Montgomery County, compared to a large national business, employees are relatively close in terms of geography, and there should be ways to move networks to a more integrated, outcome based system. At the same time, care needs to be taken to focus resources on those with chronic conditions and not waste resources by having a one size fits all approach that would provide extra management to people who don't need much management.

These comments are not about a short-term solution but rather a long-term strategy to change the health care delivery system.

***What is value-based purchasing or contracting?***

Value-based purchasing is not only being pursued in the private insurance sector but is an important part of Medicare reform that is looking to contain cost increases by improving the quality of health care and reducing unnecessary health care expenses.

1997 and 2010 reports from the Agency for Healthcare Research and Quality (AHRQ - part of the U.S. Department of Health and Human Services) use the following definition of Value-based Purchasing:

"The concept of value-based health care purchasing is that buyers should hold providers of health care accountable for both cost and quality of care. Value-based purchasing brings together information on the quality of health care, including patient outcomes and health status, with data on the dollar outlays going towards health. It focuses on managing the use of the health care system to reduce inappropriate care and to identify and reward the best-performing providers. This strategy can be contrasted with more limited efforts to negotiate price discounts, which reduce costs but do little to ensure that quality of care is improved."

The 2010 AHRQ report also cites a 2002 report from the Midwest Business Group on Health that estimated that the direct cost of poor quality care for employers was \$1,350 per employee per year, while the indirect cost of poor quality care, including lost time and productivity, was at least \$340 per year. The goals for value-based purchasing include: (1) improved health status, (2) greater satisfaction with health plans and care delivery, (3) lower costs, and (4) greater competitiveness in the labor market.

In October 2011, The Taconic (New York) Health Information Network and Community (THINC) issued a report on a February 2011 workgroup session with health

plan representatives and health care providers to discuss issues regarding collaboratively forming value-based payment arrangements. The report says, "Providers and health plans are being motivated by a growing sense that costs and budgetary constraints will inevitably require significant movement away from the fee-for-service model." The report highlights the need to resolve issues around how risk will be shared between providers and plans (gain-sharing vs. loss-sharing), access to information including utilization and prescription drugs, and funding support for professionals such as case managers, nutritionists, and home health workers to coordinate care in a less costly setting. Providers and health plans are concerned about how quality will be evaluated, and some health plans are concerned that the value-based approach will fail to result in the cost savings and quality that are the intended outcomes.

In part, the move to develop value-based purchasing models is being driven by the Medicare Shared Savings Program, a voluntary program under the federal health care reform law to move providers from traditional fee-for-service to providing more effective coordination of care through Accountable Care Organizations (ACOs). Accountable Care Organizations are provider led organizations that tie provider reimbursement to quality and outcome of care. They can have different reimbursement models that include fee-for-service or capitation, but there is an incentive, or shared savings or loss, attached to improving health outcomes and reducing the cost of overall care.

Medicare has also begun providing information to consumers about quality through a 5-Star rating system for Medicare Plan providers. There are measures associated with each of five domains: (1) Staying Healthy: Screenings, Tests, and Vaccines; (2) Managing Chronic (Long Term) Conditions; (3) Ratings of Health Plan Responsiveness and Care; (4) Health Plan Members' Complaints and Appeals; and (5) Health Plan Telephone Customer Service. This rating system is not just a useful example of consumer information, it is also a basis on which the Center for Medicare and Medicaid Services (CMS) will provide bonuses or penalize plans both in terms of rates and whether they are allowed to enroll beneficiaries year round (high star plans will but others are confined to a limited period of enrollment).

**3. Montgomery County has an opportunity to create an innovative health care delivery system for its employees and their dependents. There may be an opportunity to start these efforts through a pilot program that approaches the request for proposal (RFP) and contracting process in a new way, focusing on wellness and aggressive disease management.**

The pilot program could focus on one or more groups of employees so that it could address their specific needs and conditions and evaluate specific outcomes. The Wellness Committee agrees that this effort will require spending in the short-term but should result in long-term savings and improved health.

**4. There should be incentives to increase participation in disease management programs.**

The King County Health Reform Initiative uses monetary incentives related to out-of-pocket expenses for health care (deductibles, co-insurance, and co-pays), which has resulted in very high participation rates (80% to 90%). The incentive is based on completing an HRA and participating in an action plan – not on a specific health result such as weight lost or a reduction in high blood pressure.

In the previous section on employee wellness, the Task Force voiced concerns over HRAs which would still have to be addressed if a King County or Johnson & Johnson type model were pursued.

The Wellness Committee recommends that the agencies should start to look at incentives for participating in disease management programs given the long-term savings that could result if chronic conditions are controlled. This is not a recommendation for a full restructuring, but there should also not be a prohibition about looking in the longer term at something innovative with proven results.

**5. The agencies should entertain disease management proposals separately from the health plan providers.**

The Wellness Committee is intrigued by the information that was provided on using an outside entity for disease management (as opposed to the plan provider). There may be more effective program models than those offered by the health plans. In addition, a single disease management program could be implemented regardless of which health plan the employee elects (with the exception of Kaiser). On the other hand, having a separate disease management program could add costs (if plan providers do not reduce costs by the amount of the outside contract), and there would have to be strict agreements in place about the sharing of patient information from the plans to the disease manager. The plan providers may propose increased costs based on the need to share information.

The agencies should consider issuing a separate competitive request for disease management services that could be bid on by a range of outside vendors, hospitals, and physicians, as well as plan providers.



## **Section 3**

### **Recommendations and Comments from the Consolidation Committee**

#### **Reasons to Look at Consolidation**

The Council asked the Task Force to study the potential for containing costs through plan and administrative consolidation. After reviewing the information provided to the full Task Force, additional information on CARS, and examples of jurisdictions or organizations that have consolidated models, the Consolidation Committee offers the following as important reasons for analyzing various consolidation options. The Committee acknowledges the work that all of the agency staffs have done to coordinate the procurement of health care benefits, to work within their current organizational structures to leverage economies of scale, to make difficult choices that may require eliminating a health plan, and to work within constrained budgets.

1. Health care benefit costs have increased substantially over the last decade. Despite having slower growth than expected in FY11, health care costs are projected to increase substantially in future years. Everyone involved in this process, employees, agencies, unions, and taxpayers, has a very real interest in working to reduce the rate of increase.
2. Both the agencies and the unions have put a great deal of thought and work into health care benefit issues, and both have a great deal of information that should be considered. Moreover, the collective bargaining process has been an influential element in the development of the current system of health care benefits.
3. Health care benefits are changing in ways both large and small, both obvious and subtle:
  - a. As the federal health care reform law is implemented we are likely to see systemic changes in the provision of health care benefits.
  - b. Even if the federal health care reform law is revoked or substantially modified, health care benefit cost increases will likely also drive changes in the provision of health care benefits.
  - c. Given increasing market choices, making the best-informed collective judgment across the entire spectrum of health care benefits is important.
4. Health care benefits are an essential employee benefit. Providing health care benefits is a core agency commitment, although the actual purchase of health care benefits is not the core function of any County agency.

5. There are multiple examples and varying models of health insurance consortiums for local units of government across the country:
  - a. The most common reasons cited by other jurisdictions for establishing a health insurance consortium across agencies were to achieve economies of scale and reduce and/or stabilize health insurance costs.
  - b. There are different ways to establish the governance structure for a health insurance consortium. Many consortiums with consolidated plan administration are governed by a Board of Directors with both agency and employee/union representation.
  - c. The process for establishing a consortium is neither simple nor quick. It takes a substantial commitment of time and effort from all participants.
  - d. A successful consolidation requires a realistic implementation timeline and effective communication among all affected parties.

### **Existing Process for Cross-Agency Collaboration**

For over twenty years, the County and bi-County agencies have used a cooperative joint competitive bid process for selecting vendors to administer their group insurance programs. The agencies use a single coordinated request for proposal (RFP) process for each type of group insurance (medical, prescription, dental, vision, etc.). As part of the joint procurement, the agencies ask that vendors bid on administering each agency's existing plan design and level of benefits. In addition, vendors are asked to view the agencies as a single entity for the purpose of proposing fixed administrative fees and plan costs. Depending on agency needs and timing, joint RFPs have covered two or more agencies.

Historically, the joint bid process allowed, but did not require, agencies to make uniform decisions about which plan vendors to select. In most instances, the RFPs have included a provision that vendor selection decisions may vary from agency to agency. More recently the agencies agreed to make uniform decisions where possible, thereby maximizing economies of scale.

Overall, the joint process requires a high level of collaboration and coordination between agency staff in terms of preparing material for the bid process and reviewing and analyzing vendor responses.

Agency staff note that while each agency has traditionally made separate decisions on group insurance vendors, the joint bid process has led to significant savings in administration through creating economies of scale. In particular, the joint bid process has led to administrative savings in prescription drug coverage, where the agencies have uniform vendor arrangements despite having different prescription drug plan designs.

## **What Does It Mean To Consolidate?**

The Committee discussed that consolidation of group insurance can mean different things to different people. Resolution 17-107 put forth three ways to look at consolidation: consolidate agency plans under fewer vendors, consolidate offerings under one administrative unit, and consolidate offerings under a uniform plan design. The Committee did not explore consolidation under a uniform plan design but chose to look at other ways to consolidate.

The Consolidation Committee discussed different forms of consolidation, including:

### **1. Consolidate data collection and analysis**

No formal process exists for collecting and analyzing claims and related cost data across the agencies. Currently, agency staff work closely together in developing requests for proposals and contracting and have some shared understanding of the health care trends facing each agency. However, there is no analysis for policy makers to use in assessing how models of administrative or plan design consolidation might impact health outcomes or costs. One form of consolidation could involve joint collection and analysis of multi-agency health claims and cost data.

### **2. Consolidate Purchasing Practices**

As previously described, the agencies coordinate the procurement of their RFPs for health care. However, at this time, each agency makes separate and independent decisions on what to buy, the type of plan, and plan designs. Greater consolidation of purchasing could include: (a) consolidated decision making on what to buy (possibly including common plan design); (b) coordinating vendor selection across agencies; and/or (c) using common criteria to evaluate vendor bids.

### **3. Consolidate Budgeting**

Currently, each agency develops its own budget for health care benefits. Alternatively, the County could create a single, unified budgeting process encompassing health care benefits for all County agencies.

### **4. Consolidate Administration**

Consolidation of administration, even in the absence of consolidation of health plan designs, could improve the efficiency of dealing with health plan administrators (both third party administrators and health maintenance organizations), communicating and responding to covered participants in the health plans, and administering associated programs in wellness and disease management.

The Committee asked staff to provide examples of existing multi-agency arrangements to administer public sector employee group insurance programs in a coordinated fashion.

### ***Models of Consolidated Insurance Pools***

The Consolidation Committee reviewed information on four examples of consolidated public sector insurance consortiums. The following provides a brief summary of each. Additional information is included in Appendix J.

#### **A. Monterey County (CA) Schools Insurance Group**

The Monterey County Schools Insurance Group (MCSIG) is a Joint Power Authority that was created and operates under the Governance Code and Education Code of the State of California. The MCSIG has 25 participating agencies that are mostly local school districts but also include one community college and two charter school organizations. There are 5,700 active enrollees and 1,200 retirees. MCSIG operates a self-insured health fund. MCSIG coordinates all health plan administration and management and has seven full-time staff.

When MCSIG was first established in 1982, each member organization had its own individual plan designs. Consolidated plan designs for medical and prescription drugs were created in 1989 and for vision and dental in 1996. MCSIG staff reports the process for each took about two years. Currently, MCSIG offers five medical plans (each with bundled prescription), two dental plans, one vision plan, and carve-out plans for behavioral health and chiropractic services. Each type of coverage is offered through a single provider. The contracts are competitively bid on three-year cycles. Pre-Medicare retirees are offered the same plans as active employees. Medicare eligible retirees have an option to stay in a full-coverage PPO plan or move to a Medicare supplement plan.

MCSIG does not negotiate with any collective bargaining organizations. Local school districts bargain with their own unions, but there are no separate plan designs for different jurisdictions. Premium cost share is determined by each school district.

MCSIG is governed by a 35-member Board of Directors that includes one representative from each participating agency, nine labor representatives, and one retiree representative. The Board has five standing committees: Executive Committee, Advisory Committee, Claim Appeal Committee, Wellness Committee, and Finance Committee.

MCSIG staff shared the following four “lessons learned” and/or recommendations to share with other agencies considering consolidation:

- It is important that every agency has a seat on the board;

- Employees should be involved in the governance structure of the program (MCSIG staff reports that most Joint Powers Authorities in California do not have labor representatives);
- Health costs should be tracked and rates set by the entire pool as opposed to separate rate setting from each participating agency; and
- A realistic implementation timeline and effective communication are integral components for consolidation.

## **B. Baltimore County, Maryland**

The Baltimore County Government Office of Budget and Finance's Division of Insurance administers most elements of the employee health insurance program for the five participating agencies: Baltimore County Government, Baltimore County Public Schools, Baltimore County Public Libraries, Baltimore County Revenue Authority, and the Community College of Baltimore County. The Division of Insurance has six staff members responsible for managing health insurance offerings. Human Resource offices in each of the participating agencies manage open enrollment.

Baltimore County agencies offer four medical plans (each bundled with prescription coverage), three dental plans, and one vision plan. The contracts are competitively bid on a three-year cycle. With the exception of Kaiser Permanente, the group insurance plans are self-insured.

The participating agencies bargain health insurance premium cost shares with their employee unions.

The County Office of Budget and Finance consults with other agencies regarding employee health insurance offerings. Union representatives, sitting on the "Health Care Review Committee," develop labor's positions on group insurance offerings for submission to the County Executive and the agencies' governing bodies. Ultimately, the County Office of Budget and Finance makes final decisions about health insurance bidding, selection of providers, plan design, premiums, and claims management.

The current structure has been in place since the mid-1990's. While there is no written statement of goals for consolidation (and current staff was not in place when consolidation occurred), there is a general understanding is that the structure was put in place to save money.

## **C. County Employee Benefits Consortium of Ohio (CEBCO)**

The County Employee Benefits Consortium of Ohio (CEBCO) is a health benefits consortium available to county governments in Ohio. It was created by the County Commissions Association of Ohio in 2004. CEBCO limits participation to "smaller counties" (the largest has 1,500 employees). There are 9,700 active employees enrolled. There are no retirees because retiree group insurance is offered through the state-run Public Employees Retirement System. There are currently 23 participating

counties and two more are expected to join. CEBCO has a staff of six full-time equivalents to coordinate most of the functions associated with providing group insurance (plan design, open enrollment, bidding, claims, and eligibility).

CEBCO offers five medical plans, four prescription drug plans, three dental plans, one vision plan, and one life insurance plan for participating counties to choose from. There is a single vendor for each type of coverage. All plans are self-insured. Contracts are competitively bid on a three-year cycle. Counties must commit to participate in CEBCO for three years. CEBCO sets premiums each year but uses separate rating pools so the premiums may vary among the members. Counties are allowed to purchase outside of CEBCO offerings, but only one county does so.

CEBCO does not negotiate with collective bargaining organizations. Health benefits are subject to collective bargaining at the county level. Bargaining occurs between county governments and their employees about whether to participate in CEBCO's plans. Premium cost share is determined individually by each county.

CEBCO is governed by a 12-member Board of Directors comprised of representatives of counties that participate in the program. Currently, ten of the Board members are County Commissioners and two non-elected officials of participating agencies. There is no union representation on the Board.

The goal of the consortium was to achieve savings in health insurance costs for member counties and to stabilize premiums. CEBCO staff reports the following as indicators of success:

- The have not had a participating county leave the consortium;
- Six counties out of 23 total will have rate decreases this coming year; and
- Medical and prescription rate renewals were lower than the industry average from 2006 through 2009.

#### **D. Greater Tompkins County (NY) Municipal Health Insurance Consortium**

The Greater Tompkins County (NY) Municipal Health Insurance Consortium was created in January 2011 by the Tompkins County Council of Governments to pool the group insurance offerings of local municipal governments. Participating agencies include the Tompkins County Government and 12 city, town, and village governments. There are 2,000 active employees enrolled and 500 retirees. There is one staff member who supports the work of the Consortium.

The Consortium administers a total of 22 different health insurance plans on behalf of the 13 participating governments. Many of the plans are similar in design but coverage, co-pay, and deductible levels vary by agency. Pre-Medicare retirees are offered the same plans as active employees. Medicare eligible retirees participate in a Medicare-supplement plan.

Each participating government separately bargains health insurance benefits with their employee unions within the parameters of the Consortium-selected offerings.

The Board of Directors is the governing body and is responsible for management, control, and administration of benefit plans. The 15-member Board consists of one representative from each of the participating governments and two union representatives. The Joint Committee on Plan Structure and Design makes recommendations to the Board regarding changes to the Consortium plan offerings. The Joint Committee has 37 voting members, one from each participating government and one from each of 24 bargaining units.

The Consortium was established with the stated mission of providing “affordable health insurance to its employees and eligible retirees...without diminishing benefits.” The Consortium recently completed a comparison that showed the average premium cost to be 3.1% lower under the Consortium’s self-insured model. Consortium staff identified three major successes of consolidation:

- Reduction in premium cost through pooling of administrative expenses;
- Retention or improvement of benefit levels for all employees; and
- Widespread acceptance of the program by both labor and elected officials.

## **Benefits and Drawbacks of Consolidation – Criteria for Evaluation**

The Consolidation Committee was not able in the time available to develop recommendations on whether to consolidate all or parts of the agencies’ group insurance plans or plan administration. However, the Committee had robust discussion that brought forth important potential advantages and disadvantages of various approaches and enabled the Committee to identify criteria that should be used to evaluate the outcomes of any proposed model for consolidation.

Different types of consolidation present different potential benefits and potential drawbacks. Some potential benefits and drawbacks apply primarily, though not necessarily exclusively, to a specific type of consolidation. Others apply to more than one type of consolidation.

### **A. Possible Benefits of Consolidation:**

1. The potential for increased leverage/negotiating power in the health insurance market that comes with a larger pool of members.
2. The potential for maximizing economies of scale through combined planning, administration, purchasing and/or plan design.

3. The potential for more macro-data collection across the entire population of covered members, thereby allowing for improved understanding of health cost drivers and opportunities for cost containment.
4. The potential to increase the efficiency and return from implementing various initiatives (e.g., disease management program) uniformly and once.

## **B. Possible Drawbacks of Consolidation:**

1. Under some forms of consolidation, employees may encounter changes in plan offerings.
2. Administrative savings alone are relatively minimal, if any.
3. Depending upon decisions made on specific plan designs, there are no guarantees that larger pools of enrolled employees will translate into potential cost containment, particularly in a self-insured environment.
4. When any function is consolidated, the decision-making structure that currently operated within the individual participating agencies inevitably has to be adjusted.
5. An impact on agency autonomy.
6. An impact on collective bargaining.

## **C. Criteria for examining consolidation options**

To best evaluate the likely outcomes of possible consolidation (or a decision not to consolidate), decision-makers need to apply uniform criteria. The Committee has identified the following non-weighted criteria for consideration:

1. Minimize long-term costs. The agencies need to obtain the most efficient (i.e., least cost) delivery of effective health care benefits that meet the needs of County employees and the obligations under the collective bargaining agreements.
2. Address the long-term impact on taxpayers. This may or may not result in accepting a bid with the lowest short-term savings.
3. Maximize incentives to contain costs.
4. Minimize disruption costs. Changing providers frequently is disruptive to both employers and employees.



5. Minimize internally imposed capture. The health care benefit system should not be captive to any provider entity, whether a Third Party Administrator or HMO, due to potential disruption to plan participants if vendor changes were made. Additionally, the County needs at least the possibility of change to enable agencies to negotiate effectively. The disruption of changing an insurer necessarily imposes some capture, but the County should work to minimize disruption.
6. Assure quality of care for all participants.
7. Address issues of agency autonomy and impact on collective bargaining.
8. Address substitution incentives. For example, participants often select plans because they want to retain their doctors. This could discourage participants from considering HMO participation.
9. Maximize the competitive position in relevant labor markets. Retain the ability to recruit, motivate, and retain a high quality work force.
10. Minimize implementation impediments. For example, agencies have different bidding cycles.
11. Provide maximum transparency.

### **Preliminary Conclusions about Consolidation**

While the Consolidation Committee is unable to recommend a model for consolidation of group insurance in Montgomery County, it has reached three preliminary conclusions:

1. There should be one central source for collective agency knowledge (data collection, storage, and dissemination). Centralized information will increase the County's knowledge of the cost and use of health care by all County employees. Currently this information is segmented among the agencies, and policymakers would be better served by having cross-agency information about what is in the best interest of the employees and the taxpayers. This additional and better quality information could be generated by staff, through consultant services, or as a requirement of the evaluation of disease management programs. It will put the County in a better bargaining position to get the best quality care for the employees at the best possible cost. It will also enhance the ability of the County to use its buying power to contain costs and improve outcomes.
2. Such a focal point does not compel uniform plan design, although it may push the County in that direction simply because certain plan designs are "better" than others for achieving the collective goals of efficiency and effectiveness as defined by improved health outcomes and reduced claims.

3. Consolidation in purchasing does not require consolidation in administration, although it may lead in that direction.

### **Issues for Further Study**

The Committee has also identified the following issues as needing further study before a decision is made on any specific proposal for consolidation:

1. Whether to consolidate some or all plan offerings among the agencies. A vast array of alternatives could be considered. For example, select one provider for HMOs or dental or vision or all medical plans.
2. Whether to establish a standard “core” benefit package for all agencies and all active members. A standard core plan could be limited to dependents or new hires. Bargaining could be permitted for enhancements to a “core” plan.
3. Whether to create incentives for consumers to contain costs.
4. Whether to consolidate wellness programs across agencies.
5. Whether to consolidate disease management programs across agencies. The cost of health care benefits is heavily weighted toward a small percentage of the total employee population. While we should not, and must not, stigmatize people for large health care benefit costs, acting in ignorance of how the budgeted dollars are being spent is equally inappropriate. This will require further analysis on how to proceed. The Wellness Committee report discusses the 80%/20% rule that, in general, 80% of expenditures are made for 20% of people covered.
6. How to evaluate the role of the Third Party Administrator. It may not be accurate to look at the network affiliated with a given Third Party Administrator as if it is just a claims administrator. Rather, the Third Party Administrator may have a financial interest in maximizing provider revenue that goes beyond simply a percentage of claims paid. We need to understand more completely what financial benefits the Third Party Administrator derives from their networks. Put another way, buying a Third Party Administrator with a network may not be so “self-insured” as we traditionally assume.
7. Whether to consolidate budgeting for health care benefits. The health care benefit plans offered by County agencies are part of complex and intricate organizational and compensation systems with numerous moving parts and a variety of stakeholders. Developing an efficient and effective multi-agency system for health care benefits using an externally mandated top-down strategy will be extremely difficult. The County budget process (such as a modification to the spending affordability process) could offer an opportunity to establish a framework to limit resources and have the autonomous entities set priorities and

make choices. An alternative would be to create incentives for a bottom-up approach where the participants are motivated to develop the changes.

8. Whether to consolidate staffing and administrative functions.
9. Whether to generate cross-agency data collection and analysis. The cost of technology changes that may be needed to generate cross-agency data or to consolidate administrative functions must be a part of any further study.
10. Whether to consolidate plan purchasing in a single HMO option as a means to maximize savings from care coordination and increased use of disease prevention and management.

### **Observations Regarding Consolidation of Administrative Staffing**

There are no magic bullets in health care, and any changes will be incremental. Staff consolidation may not reduce total administrative cost. In any event, the maximum potential savings from staff reduction would likely be extremely modest in the context of total plan costs.

The Consolidation Committee makes this statement based on its review of the FY11 staffing and personnel costs included in the March 22, 2011 OLO memorandum to Councilmembers that showed a total of 24.2 workyears and about \$2.3 million in personnel costs for administration of the MCPS, County Government, and Montgomery College group insurance plans. Even a substantial percentage reduction would be a minimal dollar amount compared to the amount that could be saved by finding ways to reduce the amount of money spent paying claims

While significant savings will not come from reduced staffing in a consolidated single administrative entity, there is potential benefit from improved efficiency and effectiveness in the overall plan operation. Reorganizing within a single entity could allow for staffing with a broader skill set without increasing the budget. This could help achieve a reduction in claims and in the costs associated with processing claims. The ever increasing complexity of the health benefit world will require a broad set of skills to keep up with and analyze the changes that are sure to come. For example:

1. Taking advantage of the changes – indeed not getting run over by them – will require:
  - a) Several people with comprehensive knowledge of a complex and sometimes very opaque system; and
  - b) Adequate flexibility (keeping in mind factors such as the disruption of changing providers and the requirements of collective bargaining).
2. To be most effective, the procurement process going forward will require significant, ongoing effort in at least two areas:

- a) Expertise about actual provider costs (either in-house or retained) to negotiate most effectively with providers; and
  - b) Greater understanding of the actual costs to the agencies and employees of various coverage options.
3. Consolidation could take the form of an independent entity or an office in one of the agencies (for example, the Baltimore County office is in the Executive Branch Office of Budget and Finance).
  4. An alternative for further analysis is California's Joint Powers Authority as implemented by the California Public Employees' Retirement System (CalPERS). Based on anecdotal data, it may offer some useful approaches both as an organizational model and for cost reduction.

## Section 4

### Summary of Presentations to the Task Force

The Task Force held a kick-off meeting on July 21, 2011 and then met weekly from September 5, 2011 through November 15, 2011 and again on November 29, 2011. The Committee received presentations from each of the agencies as well as from consultants and organizations on issues related to health care cost containment, contracting, consumer-driven health plans, and the advantages of a staff model health maintenance organization. Copies of these presentations are included in the appendices to this report. The following provides a summary of the information reviewed by the Task Force.

- The Task Force received a presentation from the **Office of Legislative Oversight (OLO)** on health care trends and options for consolidation previously provided to the Council.
- The Task Force received **overview presentations from Montgomery County Public Schools (MCPS), Montgomery County Government (County Government), Maryland-National Capital Park and Planning Commission (M-NCPPC), Montgomery College (College), and the Washington Suburban Sanitary Commission (WSSC)** on the numbers of people enrolled in health plans, their current and planned 2012 health plan offerings, and employee wellness and disease management programs. (Appendices D, E, and F)
- At the September 27 meeting, **AON-Hewitt** presented information **comparing the 2012 agency health plan offerings and 2011 enrollment data** and analyzing population and expenditure information for MCPS and County Government. This information was provided in an October 17, 2011 report. A revised version of the report, forwarded by AON-Hewitt on November 21, 2011 is included in Appendix B. The report includes information on insurance carriers, plan types, percentages of actives and retirees covered by the plans, opt-out rates, and type of coverage (single, family), employee contributions, and average premium costs for active employees. For MCPS and County Government, AON-Hewitt reviewed per member costs (associated with active employees), demographics of enrollees, enrollment trends, claims history, and plan design differences.
- At the September 27 meeting, the Task Force also received a presentation from **Dr. Thomas Sawyer**, Health Directions Consulting LLC and consultant to MCGEO Local 1994, ***Alternatives to Cost Shifting: Managing Cost through Improving Plan Value***. Dr. Sawyer's presentation is included in Appendix G. Dr. Sawyer highlighted the reasons why employers and employees are so focused on the cost of providing health care: declining revenues, aging workforce, increased cost for health services and new specialty drugs. His

presentation focused on alternatives to cost shifting, which he said impacts the poorest and the sickest the most. He emphasized focusing on clinical outcomes and wasted health care dollars. Dr. Sawyer noted that implementation of cost savings measures such as step therapy could save the County Government as much as \$5 million. Dr. Sawyer recommended regular audits of prescription drug programs. Better care coordination and the unbundling of services (including administration and stop-loss insurance) could also help contain costs. Dr. Sawyer said that many organizations are moving to value-based design. He also said that as a general rule, about 15% of people use 80% of health care dollars.

- At the October 11 meeting, the Task Force received a presentation from **Dr. Paul Fronstin** of the Employee Benefits Research Institute, ***What Do We Know About Consumer-Driven Health Plans?*** Dr. Fronstin's presentation is included in Appendix I. Consumer-Driven Health Plans (CDHPs) are generally high-deductible health plans that are partnered with a Health Reimbursement Account (HRA) or a Health Savings Account (HSA). With an HRA, the employer holds the account that is used to reimburse the employee for out-of-pocket expenses. In an HSA, the employer puts money into an account that is owned by the employee. The employee manages the account and the employee may save the money from year to year and can retain the account after leaving the employer. In 2011, 23% of firms offering health plans offered a high-deductible health plan with an HRA or HSA. There does not tend to be an age difference for those in CDHPs compared to other plans, but they tend to be less likely to smoke or be obese and are more likely to exercise. People with higher incomes are more likely to take the risk of a high-deductible plan. Because high-deductible plans have lower premiums than traditional plans, savings from lower premiums can be recycled into the HSA to cover out-of-pocket costs. Dr. Fronstin also noted that in terms of savings, one study showed annual savings of 4.5% but after adjusting for risk selection (healthier people tend to select CDHPs) this dropped to 1.5%. While there are savings to employers in the first year of adopting CDHPs because of the lower premiums associated with high-deductible plans, the trajectory for percentage increases will eventually be the same as for traditional plans. There is a need to educate people about CDHPs if they are implemented. With regard to wellness, Dr. Fronstin said that surveys shows that higher percentages of those in CDHPs are more likely to participate in health risk assessments and health promotion programs if they are offered. Dr. Fronstin noted that with regard to engaging people in disease management, some people are moving away from traditional programs that are telephone-based and are focusing on value-based contracting.
- At the October 18 meeting, the Task Force received a presentation from **Laura Walsh**, CEO of Associated Administrators, LLC, ***Contracting for Disease Management, Specialty Pharmacy, and Step Therapy***. Ms. Walsh's presentation is included in Appendix J. Ms. Walsh is a Third Party Administrator for multiple health care funds, including Taft-Hartley Funds. Ms. Walsh noted that cost containment can be modeled around chronic conditions, such as

diabetes and heart disease, or around people with medical expenses that exceed a certain amount. When contracting for disease management, it must be clear who is responsible for identifying people for services, and there must be an evaluation of how sophisticated the model is that is being used to identify those with chronic conditions. The funds she works with generally consider proposals from several disease management firms. Metrics that can be included in a contract include return-on-investment (ROI) and number of interventions. Vendors must be clear on how they will calculate ROI. For example, one avoided hospitalization might cover the cost of the disease management programs for several months. Successful disease management requires information be shared regularly between the medical plan and the disease manager, and the disease manager should provide regular reports to those supervising the fund. Ms. Walsh discussed specialty pharmacy programs that focus on very expensive injectable drugs. In a specialty pharmacy program, the patient learns to self-inject at home instead of going to a doctor's office. There can be substantial savings; she noted that a drug that might cost \$5,000 in a doctor's office and cost \$1,000 if it is delivered to the patient's home. Ms. Walsh noted that specialty pharmacy contracting can be very complicated and that information must be HIPAA protected. Step Therapy requires the use of certain generic or preferred drugs before a brand-named drug can be used. Because of the proliferation of generic drugs, Step Therapy is becoming less popular and somewhat obsolete. It is usually an adjunct to a pharmacy contract.

- At the October 18 meeting, the Task Force also received a presentation from **Fariba Kassiri, Assistant Chief Administrative Officer for Montgomery County**, on the **Cross-Agency Resource-Sharing (CARS) initiative**. Information on CARS is included in Appendix J. Wes Girling, Benefits Manager for Montgomery County Government, had previously shared some information about CARS during the agency overview presentations. Ms. Kassiri told the Task Force that the goal for CARS, which started in February 2010, was to find \$1 million in savings for FY12 and that the goal was achieved. With regard to the employee and retiree benefit plans, ten possible ways to achieve savings were suggested by the Benefits Subcommittee for CARS: (1) Consolidate employee benefit plan offerings, (2) Combine COBRA and Flexible Spending Plan administration, (3) Consolidate and bring payment of retiree benefits in house, (4) Consolidate defined benefit retirement programs of County agencies under one program, (5) Consolidate employee benefits plan offerings of County agencies under one administrative unit that supports all County agencies, (6) Jointly develop wellness and disease management strategies, (7) Jointly approach light duty and return to work strategies expanding County Government Occupational Medical as a resource for all county agencies, (8) Consider a uniform plan design across agency lines whether or not the plans are consolidated, (9) Consider combining drug and alcohol testing across the agency lines and explore leveraging the contracts with health insurance vendors, and (10) Consolidate the County Government and MCPS (and perhaps other agency) processes to evaluate applications for disability retirement. Mr. Girling noted that Items #1, #5,

and #8, which consider consolidation and uniform plan design, are all part of the work of the Task Force and are extremely complicated issues. He said that the members of the CARS Benefits Subcommittee are all agency representatives of the Task Force and have deferred further work as CARS while the Task Force completes its work.

- At the October 25 meeting, the Task Force received a presentation (Appendix K) from **Dawn Audia**, Executive Director of Account Management for the Kaiser Foundation Health Plan of the Mid Atlantic States, **Dr. Jaewon Ryu**, Associate Medical Director, and **Patricia Nicholson**, National Coordinator for the Coalition of Kaiser Permanente Unions. The Task Force asked Kaiser to present because they are a staff-model health maintenance organization. Kaiser representatives said that wellness and disease management are integrated into their health services. In contrast to the fee-for-service model in which patients must coordinate their own primary, specialist, and pharmacy care, all Kaiser providers have access to a comprehensive medical record for each patient that identifies best practices specific to each patient's conditions and treatments. Dr. Ryu described how following best practices for people over age 55 taking certain diabetes medications can result in reduced hospitalizations. With regard to pharmacy, Kaiser members fill their prescriptions 95% of the time because pharmacies are a part of the medical center. In fee-for-service systems prescriptions are filled only about 80% of the time. Kaiser is the second largest purchaser of pharmaceuticals after the Federal government, and this helps Kaiser contain costs. Kaiser was asked whether they have local capacity to serve a substantial number of new clients. Kaiser responded that they could accept many new members as they are expanding their facility capacity, including opening a new center in Gaithersburg. Kaiser responded to concerns raised by Task Force members regarding perceptions about the time it takes to see a doctor, the ability to select a specialist, and the ability to select alternative treatments. Kaiser said that most people can see a doctor on their first call and that the time to see a specialist has improved. In-house doctors are used first, but Kaiser has contracts with outside specialists for cases where Kaiser staff does not have the needed expertise. Kaiser said that it sets rates based on claims experience and risk. Kaiser said that it has lower rates than other providers when combining the cost of medical and pharmacy plans. Kaiser estimated that if all the agency members currently in HMOs elected Kaiser, the County would save \$27 million per year. The Task Force also received information from Kaiser on its partnership with its unions and its labor-management wellness committee.



## **Section 5**

### **Comments from Individual Task Force Members/Minority Views**

**Minority Opinion**  
**Joan Fidler, Public Member**

This minority opinion focuses, in large part, on the Consolidation section of the Report. It does not in any way gainsay the time, effort and thought expended by all the members of the Task Force in developing the final report. It must be stated, however, that the representational makeup of the Task Force - county workers, union representatives and public members - fostered discussion but mitigated against unanimous approval of all the recommendations.

It should be noted that this minority opinion represents the view of a Montgomery County taxpayer, whereas not all county workers and union representatives are taxpayers in Montgomery County and thus might share a different view. And yes, some public members might subscribe to the same view as that of county workers and union representatives.

Both the Background and Consolidation sections, but especially the latter, appear to be largely in support of the *status quo* and are therefore disappointing. There is little discussion on affordability, actual costs and savings, without which the Report quickly becomes a compendium of ideas almost all of which will require further analysis. The Background section on Collective Bargaining, a subject that constantly injected its way into any discussion related to change, cast a pall on new ideas. While admittedly collective bargaining is a right and a reality in the governance of Montgomery County, for purposes of this Task Force, and in my view, it was a barrier to the advancement of many avenues of discussion. "That will be a subject for collective bargaining" or a variation thereof was the leitmotif of many discussions.

And now to the Consolidation section of the report. Coordination, it was claimed by both county workers and union representatives, works very well among the 5 agencies. However it appears that this coordination has rarely resulted in consolidation. There appears to be a gentleman's agreement to not intrude on another agency's turf. This was quite apparent in many of the discussions of the Consolidation Committee.

Many arguments were made about the uniqueness of each of the five agencies, a uniqueness that has resulted in 5 different health care systems. Worse, it has created a caste system whereby MCPS workers pay an exceedingly low share of their health care premiums (5-10%), M-NCPPC workers pay 15%, WSSC 20 - 22%, Montgomery County Government workers 20-25%, while Montgomery College workers pay the highest share (25%) (AON Hewitt Report presented to the Task Force on September 27, 2011). This smacks of gross inequity. Yet, remarkably, any attempts to discuss uniformity of plan design were studiously and deliberately avoided. In December 2010, OLO Report 2011-12 stated that the savings that would accrue from a uniform design where all workers paid 25% of their health care premiums would be around \$46 million in FY 2012 rising to \$123 million by FY 2016. The Task Force did not address these cost savings.

While I agree with the first "Preliminary Conclusions about Consolidation", I do not agree with the tentative nature of the other two.

Thus in the Task Force report, the second "Preliminary Conclusions about Consolidation", reads thus:

"Such a focal point does not compel uniform design (though it may push us in that direction simply because certain such plan designs are "better" than others for achieving the collective goals of efficiency and effectiveness as defined by improved health outcomes and reduced claims)"."

My minority version reads thus:

"While information centralization does not compel uniformity in plan design, there is no reason it should not. All county employees work within the relatively small area of the county which should be attractive to health insurers. By having uniformity in plan design, it would further the stated goal of the County Council to treat all employees equally".

Again, in the Task Force Report, the third "Preliminary Conclusions about Consolidation" reads thus:

"Consolidation in purchasing does not require consolidation in administration – though it may lead in that direction".

My minority version:

"Along with the consolidation of purchasing it logically follows that there should be a consolidation of administration. These two activities function most effectively when they work together. To have consolidation of purchasing while maintaining decentralized administration will not allow the system to work as effectively as possible. The Federal Government has 8 million participants spread around the world. Yet it operates with consolidated purchasing and administration in the Office of Personnel Management. And given that many of the county's taxpayers are federal employees and retirees, many will wonder why the county can't similarly consolidate. (For more information on this conclusion, see Task Force Report section on Observations Regarding the Consolidation of Administrative Staffing).

In conclusion, the emphasis is on maintenance of agency autonomy and impact on collective bargaining than on fiscal affordability and impact on county governance.

— Joan Fidler  
Public Member